

**Abstracts of Interpretations of
Adult Care Home Rules
and
Residents' Bill of Rights**



**North Carolina Department of Health and Human Services
Division of Facility Services
Adult Care Licensure Section
May, 2004**

North Carolina Department of Health and Human Services
Rule Interpretations

Table of Contents

Activities - Section 100

- none at this time -

Admission & Discharge - Section 200

14-day notice - 200-3

Alcohol & drug treatment - 200-2

Cease operations - 200-3

Discharge hour - 200-1

Failure to pay for meds - 200-3

FL-2 for transfer - 200-3

Grievance policy - 200-2

Security deposit - 200-2

Sign-in policy - 200-2

Time for refund - 200-3

Written agreement - 200-1

Building, Fire Safety & Other Requirements
Section 300

Alarms - 300-2, 300-3

Ambulation status - 300-4; 300-10

Basements - 300-4

Blankets - 300-4

Building temperature - 300-5

Bunk Beds - 300-8

Corridors & furniture - 300-4

Double key lock in FCH - 300-1

Drawer space - 300-4

Electric blankets - 300-7

Emergency/fire exit - 300-11

Fire rehearsals - 300-10

Folding chairs - 300-5, 300-6

Furnishings - 300-1; 300-11

Handbells/signaling devices - 300-2

Local inspections - 300-10

Mobile/modular homes - 300-12

Building...(continued)

Non-resident spouse - 300-8

Non-skid surfacing - 300-1

Portable Heaters - 300-8

Privacy curtains - 300-5, 300-9

Room locks - 300-3

Rugs - 300-6, 300-7

Single hand motion locks - 300-7

Smoke detectors - 300-9

Smoking area - 300-9

Space requirements & family - 300-7

Special Care Unit - 300-11

Towels & washcloths - 300-11

TV & Radio - 300-1

Washing Machines - 300-9

Charges/Cost of Care - Section 400

Bank service charge - 400-2

Barbers/beauticians - 400-8

Entrance Fee - 400-3

Incontinence supplies - 400-2; 400-5; 400-9;
400-11

Laundry - 400-11

Meals - 400-1

Medical Equipment - 400-3; 400-10

Modified diets - 400-1

Personal funds - 400-6; 400-7; 400-8; 400-10

Private rooms - 400-4

Rates - 400-4; 400-5; 400-10; 400-11

Refund policies - 400-5; 400-6; 400-9

Sitter - 400-5; 400-10

Social Security - 400-7

Third party payments - 400-8

Toiletries - 400-3

North Carolina Department of Health and Human Services
Rule Interpretations

Table of Contents

Food Service - Section 500

Canned fruits & vegetables - 500-4
Cleaning/housekeeping - 500-2
Day programs - 500-3
Egg products - 500-2
Feeding techniques - 500-5
Grains - 500-5
Juice - 500-2
Leftovers - 500-2
Management of food services - 500-4
Menus - 500-3; 500-4
Modified diets - 500-1
Protein - 500-5
Receipts/invoices - 500-2
Refrigerator temperatures - 500-1
Religious preferences - 500-4
Supplements - 500-5

Forms/Records - Section 600

Bedhold - 600-1
Criminal history checks - 600-3
Health Care Personnel Registry - 600-4
Lab results - 600-4
Personnel files - 600-1
Physician signature - 600-2
Regulatory review - 600-3
Resident records - 600-2
TB test - 600-2
Temporary employee files - 600-1
Time frames - 600-4
Written instructions/emergencies - 600-2

Health Services - Section 700

Emergency personnel - 700-2
Family Nurse Practitioner - 700-1
FL-2 - 700-2
Infection Control - 700-3
Portable gates - 700-3
Reassessments - 700-2
Verbal orders - 700-1
Weights - 700-3

Licensure Issues - Section 800

Adult day care - 800-1, 800-3
Apartments - 800-2
Illegal drug use - 800-1
Private living areas - 800-1
Provisional licensure renewal - 800-1
Public records - 800-2

Medication Management - Section 900

Advance preparation - 900-2
Borrowing medications - 900-2
Crushing medications - 900-8
Discontinuation - 900-3
DMA 3050 - 900-6
Emergency locked box - 900-3
Epipens/Auto injectors - 900-12
Family member responsibility - 900-1
FL-2 - 900-1
Herbal medicines - 900-9
Labels - 900-5, 900-8

**North Carolina Department of Health and Human Services
Rule Interpretations**

Table of Contents

Medication Administration continued

Medication orders - 900-6, 900-7
Medication review - 900-2
Non-prescription medication - 900-7
Pharmacy choice - 900-3
PRN Medication - 900-8
Samples - 900-8
Self-administration - 900-9, 900-10
Signatures - 900-6
Skills validation - 900-11
Storage Box - 900-4
Temporary absence/aides - 900-11
Temporary absence/residents - 900-4
Time frames - 900-9, 900-12
Unqualified aides - 900-11

Personal Care & Transportation - Section 1000

Day activities - 1000-1, 1000-3
Dialysis - 1000-1
Disoriented residents - 1000-6
Distance - 1000-1, 1000-2
Fees - 1000-3
Liability - 1000-2, 1000-5, 1000-6
Medical appointments - 1000-6
Sign-out register - 1000-4
Waking residents for personal care - 1000-4
Wanderers - 1000-4
Workshops - 1000-3

Resident Rights - Section 1100

Alcohol - 1100-1
HIV testing - 1100-4
Holiday leave - 1100-5
Medication self-administration - 1100-3
Off-site outings - 1100-2
Pharmacy/Home health choice - 1100-3, 1100-4

Resident's Rights continued

Restraints - 1100-2
Searching resident's belongings - 1100-5
Therapeutic hold - 1100-3
Tobacco policies - 1100-1
Volunteer work - 1100-1

Staffing - Section 1200

Administration - 1200-4, 1200-5
Adult day care - 1200-4
Aides and transportation - 1200-3
Dual roles - 1200-1, 1200-2, 1200-3, 1200-5, 1200-7
Housekeeping on third shift - 1200-2
Immediate availability - 1200-5
Live-in staff - 1200-6
Medication competency - 1200-07
Multi-floor facilities - 1200-1
Outside agency personnel - 1200-5
Personal care assistance - 1200-7
Relief management - 1200-1
Sitters - 1200-7
Staff sleeping - 1200-2, 1200-3, 1200-4
Supervision and day programs - 1200-6
Temporary absence - 1200-6

North Carolina Department of Health and Human Services
Rule Interpretations

Table of Contents

Assessment/Care Plan - Section 1300

Quarterly evaluation - 1300-1
Care plan - 1300-1
Assessments - 1300-1
Respite services - 1300-1

**Licensed Health Professional Support/Training
- Section 1400**

CEU's and special care units - 1400-2
Competency evaluations - 1400-1
CPR - 1400-1
English language proficiency - 1400-1
LHPS assessments - 1400-2
Out of state aides - 1400-2
Quarterly reviews - 1400-2
Relief staff - 1400-1

North Carolina Department of Health and Human Services
Rule Interpretations

Activities

Section 100

Activity rule is being updated. Interpretations to follow.

North Carolina Department of Health and Human Services
Rule Interpretations

Admission and Discharge

Section 200

1. **Question:** Is the written agreement between the administrator and the resident or his/her responsible person required when a resident leaves the home for hospitalization but intends to return to it? Is it required for such short absences as weekend leaves with family?

Answer: The intent of the written agreement outlined in the rules is to offer both the home and the resident protection from misunderstandings, which could result from unwritten agreements. The resident has his/her accommodations protected for a set number of days. The home is protected from non-payment for days the resident's bed is held.

The written agreement is not necessary in the case of hospitalization. Hospitalization of the resident is in a sense an extension of the home's care and services. It is an example of the administrator's responsibility of making arrangements with the resident or his/her responsible person for the appropriate health care needed by the resident. A resident who is hospitalized will continue to be responsible for payment of his/her adult care home daily rate until such time as a decision is made about his/her care and the home is notified of this.

If a resident is hospitalized and then found to be unable to return to the home because he/she needs professional nursing care under continuous medical supervision, the home would be entitled to payment for the days the resident was hospitalized up to the date the home is notified that the resident cannot return (up to 30 days for a recipient of State-County Special Assistance for Adults). The requirement of the notice by the resident would not be required since returning to the home would jeopardize the resident's health. In the case of the hospitalized resident who could return to the home but chooses to go elsewhere, the resident would not only owe the days of hospitalization up to the time of notice but also payment covering the two weeks notice requirement.

The written agreement is also not necessary for short weekend leaves. This can be most appropriately handled through use of the sign-out register which indicates the resident's departure time, expected time of return, and the name and telephone number of the responsible party.

2. **Question:** Can an adult care home set a discharge hour, similar to what a hospital does, when a resident is being discharged from the home?

Answer: Yes, a discharge hour, (for example 11:00 a.m.) may be set by a home to establish when a resident is expected to leave the premises. The discharge hour should be clearly stated in the home's house rules and should be explained to the resident and the person helping the resident with relocation at the time the discharge notice is given.

This does not have a bearing on settlement of cost of care since it is determined on the basis of nights spent in the home.

3. **Question:** Can an adult care home have a policy of requiring that all new admissions must be "signed in" by a responsible party?

**North Carolina Department of Health and Human Services
Rule Interpretations**

Admission and Discharge

Section 200

Answer: The rules require the administrator or SIC to furnish and review with the resident or his/her responsible person essential information on the home at the time of admission. This information includes the resident contract which must be signed and dated by the administrator or SIC and the resident or his/her responsible person. The intent of the admission requirements is to allow the resident the opportunity to exercise his/her rights as a citizen to enter into a contact with the home if he/she is competent and desires to do so without the additional agreement of a responsible person. Therefore, any requirement by an administrator to limit the right of a competent resident to sign materials on his/her own behalf for admission to a home would be in conflict with the intent of the rules. An administrator may not establish any policy, procedure or requirement that is not consistent with the licensure rules for adult care homes.

4. **Question:** Does the current rule regarding admission exceptions for people “for treatment of...alcohol or drug abuse” imply that those persons who are actively being treated for such conditions through a specific therapy not be admitted into licensed adult care homes?

Answer: Rules 13F .0701(b) and 13G .0701(b) are distinguishing between a substitute home and a treatment facility. An adult care home, by state law and by APA rules, is a substitute home. It is not a treatment facility and medical care is only occasional or incidental, such as may be given in the home of any individual or family. Thus, it follows that a person can live in an adult care home and receive incidental medical care and treatment on an outpatient basis in just the same way a person living in his own home would receive such care and treatment. It depends on the client’s condition and what his physician recommends. An adult care home, through its own staff, cannot provide treatment for mental illness or alcohol or drug abuse.

5. **Question:** What constitutes an acceptable grievance policy for an adult care home?

Answer: The intent of the section regarding a grievance policy in the rules is to ensure that a resident or his/her responsible person is informed that he/she may present complaints or make suggestions about the home’s policies and services. An acceptable grievance procedure should formally establish the course of action for a resident or his/her responsible person to follow when making a complaint or a suggestion, i.e., how and to whom is a grievance made and what resolution process does it follow once it is made. This information along with other essential information on the home is to be furnished to, and reviewed with the resident or his/her responsible person, at the time of admission in order to make all parties involved aware of the home’s operating procedure.

6. **Question:** Can an adult care home charge a private-pay resident a “security deposit,” a refundable deposit, paid at the time of admission, to cover the last month’s board rate and any damages beyond normal wear and tear by the resident to the home’s property?

Answer: This practice does not appear to violate any rules governing adult care if the home’s written agreement addresses the “security deposit” and its terms and is signed by the administrator and the resident or responsible person. This is a reasonable private business

**North Carolina Department of Health and Human Services
Rule Interpretations**

Admission and Discharge

Section 200

arrangement when the potential resident or someone acting on his/her behalf has clearly agreed to it.

7. **Question:** Do the rules require a new FL-2 form to be completed for the admission of a resident to an adult care home from another adult care home? Also, who is responsible for obtaining the new FL-2 if it is required?

Answer: A new FL-2 is required when the existing FL-2 form was completed more than 90 days before the admission of the resident [13F .0703(c) and 13G .0702(c)].

The rules do not specifically delegate the responsibility for obtaining the new FL-2 form to any particular individual. This responsibility may be assumed by the family/responsible person, the previous adult care home, the home where the resident is being admitted or the local department of social services when the resident is receiving placement services from the agency. In situations where the family/responsible person or the previous adult care home is requesting the discharge, it is reasonable to assume that the new FL-2 would be obtained by one or the other of these individuals. The home receiving the resident must assure that this requirement is met by having the completed FL-2 form available in the home.

8. **Question:** Can a resident ‘take back’ a 14-day notice once it has been given?

Answer: The purpose of the 14-day notice is to allow the facility the opportunity to make any kind of arrangements necessary as a result of the resident leaving the facility. Once the notice has been given, the facility may arrange for the admission of another resident who will occupy the bed to be vacated within that 14-day period. The facility is not under any obligation to disregard the notice if the resident wishes to withdraw it. The action is reversible only if the administrator of the home wishes to make it so and allow the resident to remain in the home. It is advised that the facility make it clear in its policies and information provided to applicants for admission that the notice by the resident is binding but may be disregarded at the discretion of the administrator.

9. **Question:** Does the notice of intent to cease operations of an adult care home on a certain date require a refund to residents moved out of the home prior to that date?

Answer: The residents, upon being notified that they are to leave the home due to the home being closed, have the option of leaving the home at any time thereafter, and are due the cost of care refund for the period of time during the month in which they are not in the home.

10. **Question:** May a resident be discharged for failure to pay his/her medication bills?

Answer: Adult care homes are responsible for assuring residents are administered medications as ordered by a physician. Medications must be available to carry out this responsibility essential to the health and safety of the residents. The facility is not held responsible for paying for medications but may have to do so to assure their availability for administration.

**North Carolina Department of Health and Human Services
Rule Interpretations**

Admission and Discharge

Section 200

If a resident or responsible party refuses to pay medication bills and not other payment options are available, the administrator may advise the resident and responsible person that the facility will not be able to meet the needs of the resident as they are licensed and, therefore, required to do and that if medication bills are not paid, plans for other living arrangements must be made. The county department of social services should be notified regarding this situation. If refusal to pay continues after this warning, the administrator may issue a 30-day notice of discharge according to licensure rules and should notify the county department of social services of the pending discharge. The discharge is warranted because the facility cannot meet the needs of the resident without provision of medications. The facility must continue to administer medications as ordered until the resident is officially discharged from the facility. If a resident is unable to pay due to lack of financial resources, the administrator and county department of social services should work together to explore other payment options before making a decision regarding discharge. While discharge under the circumstances of failure to pay for medications is unfortunate, the facility cannot be forced to maintain a resident who does not meet payment obligations, thereby requiring the facility to continue to absorb the costs.

**North Carolina Department of Health and Human Services
Rule Interpretations**

Building, Fire Safety, and other Requirements

Section 300

1. **Question:** What is meant by “non-skid surfacing” as it relates to showers and bath areas?

Answer “Non-skid surfacing” is a surface designed to prevent slipping in the shower or tub. Adhesive strips may provide this surface as may a well-maintained rubber mat which clings to the shower or tub. The local sanitarian may be able to offer advice as to which type of non-skid surfacing would be easiest to maintain and provide the greatest protection against mishaps.

2. **Question:** Isn’t there a contradiction between requiring a home to have specific furnishings and allowing residents to bring their own furnishings? Does a home have to be fully furnished before a license can be issued?

Answer: While it is the home’s obligation to provide the furnishings required by rule, the rules also allows residents to bring their own furniture and personal belongings if permitted by the home. Obviously, if a resident chose and was permitted to bring his/her own bed, bedside table, chair and chest of drawers, the home would not also need to make these same items available to the resident. The two factors, therefore, are (1) it must be the resident’s choice to bring or not bring furnishings and the home may not refuse admittance on the basis of a person’s willingness or ability to provide his/her own furnishings; and (2) all of the required furnishings must be in place at the time the resident enters the home but each vacant bedroom need not be fully furnished prior to initial licensure.

3. **Question:** May a home be exempted from providing a television and radio because of an administrator’s and some of the residents’ objection to the use of these items?

Answer: No. A home is required to provide both a television and radio for use by all residents, even if each resident has his/her own television and radio. If the home foresees a problem owing to a difference of opinion among the residents regarding use of television and radio, it may want to have a group meeting of staff and residents to plan the reasonable use of these items that will maximize exercise of the residents’ individual rights in the group setting.

4. **Question:** Would a double key lock be allowed in a Family Care Home if used only when the house is empty (e.g., residents and staff on trip or out to eat)?

Answer: This would not be allowed since there would be no way of assuring that the double lock would not be used when the residents and staff are at home as well. The rule allowing each exit door to have no more than one locking device (easily operable, by a single hand motion, from the inside at all times without keys) cannot be waived.

5. **Question:** With regard to furnishing handbells/signaling devices, what is considered “when indicated” and reasonable use” as required by Rule 13F .0901?

Answer: “When indicated,” in the context of this rule, means when the need for handbells or other signaling devices has been demonstrated. This will depend on a number of different factors such as the condition and location of the residents and the amount of staff supervision. For example, semi-ambulatory and non-ambulatory residents in more isolated wings of a home which is minimally staffed such that staff are not always present in that area, should be provided some kind of signaling device that can be heard by staff. The same applies to those semi-ambulatory residents who need mobility assistance from staff, not just assistive devices. A good guideline is that if staff are unable to check on semi-ambulatory and non-ambulatory residents at least every thirty minutes, a signaling device should be provided. Considerable health care or personal care needs as demonstrated on the resident’s care plan or problems with incontinence which is being treated with bowel and bladder retraining would also indicate the need for a signaling device to be supplied. On the other hand, a signaling device would not be indicated for a resident with cognitive impairment or dementia to the point of not being able to use a signaling device or use it appropriately. The term “reasonable use” could also be applied in situations involving residents with dementia so that, for example, if the bell is rung frequently with no indicated purpose, resident use would be contraindicated.

To meet the intent of the rule in question, an evaluation of the situation is needed from both a resident needs, staffing, and logistical perspective. If there is disagreement between the adult homes specialist and the administrator on whether a signaling device is indicated, a licensure consultant with the Adult Care Licensure Section of the Division of Facility Services should be consulted, and if necessary, a ruling can be made on whether signaling devices should be required.

6. **Question:** Rules for Adult Care Homes require a sounding device if the home serves at least one disoriented or wandering resident. Rules also allow for this device to be deactivated. When is this appropriate?

Answer: The intent of the requirement for a sounding device is to protect residents who are disoriented or have a tendency to wander. The device provides a mechanism for staff to better monitor these residents’ whereabouts. Primarily, this sounding device is most important during third shift hours when the resident/staff ratio is decreased, and the possibility of a resident leaving the building unnoticed is greater. No blanket statement has been issued specifying when this device may be deactivated. This judgment is left to the administrator based on the layout of the home, the number and location of disoriented or wandering residents, and activities which could isolate the staff to certain areas of the home away from these residents.

**North Carolina Department of Health and Human Services
Rule Interpretations**

Building, Fire Safety, and other Requirements

Section 300

7. **Question:** When alarms are deactivated, what is the staff 's responsibility in monitoring disoriented or wandering residents?

Answer: Deactivating the alarms does not absolve the staff from supervisory responsibility. In fact, deactivated alarms call for greater direct supervision (observation) by staff of residents who tend to wander. The home must have a plan in place to monitor wandering residents when the door alarms are deactivated, such as checking on the resident's whereabouts at frequent intervals. Requests for guidance from health care professionals who are familiar with a resident about the strengths and limitations of the resident would be appropriate. These professionals are in the best position to evaluate the individual needs of their client and can make recommendations about the type and amount of supervision required for this resident.

8. **Question:** In adult care homes, is it necessary for sounding devices on exit doors to remain on after the door is opened and shut until being deactivated? May a central control panel be used for the sounding device and, if so, where may it be located?

Answer: It is necessary for the sounding device to remain on after the door is open and shut until being deactivated by staff. Otherwise, staff may not be able to observe which door has activated the device. If staff are not able to determine this, the protection afforded by a sounding device to wandering or disoriented residents is significantly reduced. A central control panel that will deactivate the sounding device may be used in the home; however, the rules do not require this. The Construction Section may approve the location of control panels in areas of a home other than in a central location as long as the intent of the rule is met.

9. **Question:** Does a private bedroom, whose door can be locked by a resident, meet the requirement for personal lockable space?

Answer: The intent of this rule is to limit access to the personal lockable space to only the resident and those persons who are directly responsible for assisting the resident in maintaining the security of his/her possessions. A resident who elects to use his/her bedroom as a "lockable space" must share access with staff in the home who are required to perform their routine duties. Therefore, allowing other persons, including other staff, to have access to this lockable space would compromise the security of that space and the arrangement would not meet the intent of the rule.

10. **Question:** Is a resident allowed to lock his/her room?

Answer: The resident's door can have a door lock, as long as the resident can open the door from inside the room with a single hand motion to allow for easy egress from the room. The staff must be able to open the door from outside of the room with a key or simple tool that is always immediately available or accessible to them.

North Carolina Department of Health and Human Services
Rule Interpretations

Building, Fire Safety, and other Requirements

Section 300

11. **Question:** The Adult Care Home rules specify that family care home corridors must have a minimum clear width of three feet. The rules also indicate that the corridors must be free of all obstructions. Does this allow furniture (e.g., a desk or a hat rack) in the additional space of a wider corridor, provided three feet of unobstructed space is maintained?

Answer: No, placing furniture of any kind in a corridor would be considered an obstruction, even if the corridor were wider and maintained three feet of unobstructed space. As stated in the rules, “corridors must be free of all equipment and other obstructions.” This rule is derived from the N.C. Building Code which allows for “no obstruction to be placed in any aisle, exit, foyer, passageway, or corridor.” This statement in the Building Code applies to family care homes. Therefore, corridors must consist of continuous and unobstructed paths of travel.

12. **Question:** As stated in the Adult Care Home rules, each resident must be provided with a “chest-of-drawers or bureau when not provided as built-ins, or a double chest-of-drawers or double dresser for two residents.” What amount of drawer space is acceptable?

Answer: There is considerable variance in the design of bedroom furniture. Whether dressers or chests are used, the intent of the rule is to assure that each resident has adequate storage space for personal wear and other belongings. This requirement has been interpreted to mean at least two full drawers of space per resident.

Typical drawer space is in the range of 8-10 inches high and 24-30 inches wide. At no time should more than two residents share the same dresser or chest-of-drawers.

13. **Question:** Are adult care homes required to furnish a blanket for each resident?

Answer: Rules regarding blankets refer to “every bed,” “adequate supply,” and “on hand at all times.” In combination, these statements indicate that a blanket should always be available for each resident. A quilt is an acceptable substitution for a blanket.

14. **Question:** May an administrator use the basement of a family care home for private rental space?

Answer: A previous opinion rendered by the Attorney General’s Office is in support of the operator’s right to use space, not designated under the license for resident use, as he/she sees fit, as long as that use does not endanger the health, safety or well-being of the residents of the licensed home. This opinion does not apply to space designated under the license for resident use.

15. **Question:** Does a family care home licensed for six have to meet Residential Care Facilities Section of North Carolina State Building Code when the physician changes the ambulation status of one of the residents from ambulatory to semi-ambulatory?

**North Carolina Department of Health and Human Services
Rule Interpretations**

Building, Fire Safety, and other Requirements

Section 300

Answer: It will be necessary for the resident's physician to determine the resident's ambulation status based on the definitions in the rules for family care homes. These definitions are only applicable for the general construction and maintenance requirements of the rules.

The definitions are not meant to represent definitions of ambulation used for State-County Special Assistance. It is also important to note that this requirement applies to facilities licensed after February 1, 1983. If the physician determines that the resident does fit the semi-ambulatory definition contained in the rules, and the home was initially licensed after February 1, 1983, then the home would be subject to Residential Care Facilities Section of the North Carolina Building Code.

16. **Question:** In adult care homes licensed before April, 1984, do the rules require privacy curtains or partitions in bathrooms or tub/shower rooms with more than one toilet or tub/shower, and must they meet minimum lighting requirements?

Answer: Yes. Adult care homes are required to have privacy partitions or curtains for each toilet in bathrooms or tub/shower rooms with more than one toilet and to meet the minimum lighting requirements for adult care homes within the physical limitations of the building. All tubs or showers must also have privacy partitions or curtains.

17. **Question:** Does the temperature in the main center corridor of an adult care home have to be maintained at or below 80°F(27°C), or does the installing of fans when that temperature is reached satisfy the requirement?

Answer: The rules require that air conditioning or at least one fan per resident bedroom and living and dining areas be provided when the temperature in the main center corridor exceeds 80°F(27°C). While the rules do not state that the temperature must be maintained at or below 80°F, the intent of this requirement is that residents should be protected from extreme temperatures during summer months. Fans provided by a home may alleviate some of the stress from heat. However, there may be situations when a resident is suffering from high temperatures in a home which may require that additional measures be taken to protect the health of the individual. In all situations of extreme heat, whether the inside temperatures are above or below 80°F, the health of individual residents must be considered. If it is apparent that a resident's health and safety are compromised, measures should be taken to alleviate the heat stress.

18. **Question:** Is it permissible to use metal, unpadded, folding chairs in residents' bedrooms?

Answer: The purpose of the rule [13F .0304 (c)(5) and 13G .0314(c)(5)] is to provide a minimum of one comfortable chair, high enough for easy rising, for each resident's use in the bedroom. As the rules indicate, these chairs may be rockers or straight, with or without arms, as preferred by the resident. The home's use of metal, unpadded chairs would not meet the intent of the rule because of the lack of comfort provided as well as the fact that only the rocker or straight type chair is permissible for use in the resident's bedrooms.

**North Carolina Department of Health and Human Services
Rule Interpretations**

Building, Fire Safety, and other Requirements

Section 300

19. **Question:** Is the use of folding type chairs permitted in the activity area of an adult care home?

Answer: In the dining room, non-folding chairs which are designed to minimize tilting are required since these chairs are moved backward and forward as residents seat themselves at the dining table. A folding chair does present the danger of folding during this movement, which may lead to a hazardous situation for the residents.

While the rules do not address the types of furnishings required for an activities area, the same reasoning could apply to the type of chairs that are used by the residents in this area. Folding chairs in the activity area, or in other areas of a home, present the same risk of tilting while being used by residents, posing a possible threat to their safety. Since the rules require that homes be free of all hazards, the use of folding chairs by residents would not be advisable.

20. **Question:** The rules prohibit the use of “scatter or throw rugs.” Does the use of mats or carpets specifically designed and manufactured for the purpose of wiping one’s feet upon entering a premise, placed just before or inside an entrance, such as short weave, rubber backed, beveled or bound edged mats, violate this rule? Would a piece of rug or carpet that is secured to the floor in some manor, such as taped, nailed, or glued, and does not pose a hazard to the resident of slipping or tripping, fall within the definition of “throw” or “scatter” rug?

Answer: If carpet has been placed and secured inside the doorway of a family care home as a mat for residents to wipe their feet on upon entering the home, it would not be considered a scatter or throw rug. It is essential, however, that this carpet be completely secured to the floor in the center and on all sides. Otherwise, it is potentially hazardous to residents entering or leaving the home. Commercial doormats specifically designed for safety generally have solid rubber backing, short weave material, bound or beveled edges, and are built to remain stationary on the floor. This type of mat is acceptable for use in an adult care home and is recommended as replacement for various materials now being used in homes as doormats.

21. **Question:** May an adult care home resident use an area rug in his/her room?

Answer: An adult care home resident who wishes to use an area rug in his/her room may do so if it is well secured to the floor, or large and heavy enough so as not to be a risk for slipping, sliding or “bunching up,” and thereby creating a greater risk of falls. An area rug is designed to cover a large area of the floor and is not necessarily the same as a throw or scatter rug. While resident choice is important, safety is a key factor in determining the appropriateness of the rug use. The one problem that may arise with an area rug is the resident catching a foot on the edge of the rug. If there are incidents of the resident falling in his/her room, the situation will need to be evaluated and the rug may have to be removed.

22. **Question:** May an adult care home resident us his/her own bedside or bathroom rug?

Answer: While adult care homes are not to use throw or scatter rugs according to licensure rule, the following are the conditions under which a facility may allow a resident to use his/her own rug:

- It is the resident's own personal item that he/she wishes to use and a note is made of it in the resident's record.
- It has a rubberized secure-trip backing that prevents the rug from sliding or bunching up.
- The resident does not have a history of falls.
- It is used only in the resident's own personal area, i.e., other residents would not normally be moving through or in that area where the rug is being used.
- This information is in the facility's policies.

Decisions on this matter must be made on a case-by-case basis with the involvement of the resident and responsible party and an assessment of the risk or hazard to the resident based on his/her condition.

The facility may use a rug with a rubberized or secure-grip backing in resident bathing areas for residents stepping from tub or shower. Such use has been considered acceptable in this particular setting.

23. **Question:** Do the rules require that all doors for occupied areas in adult care homes, including offices and staff/visitor restrooms, have single hand motion locks for egress?

Answer: For resident bedrooms and bathrooms, the use of single hand motion locks is the only type of lock allowed for egress as long as staff have ready access to a key or special unlocking tool to be used on the corridor or exterior side. It is recommended that any non-resident use areas such as offices and medication storage areas which are left unlocked and are accessible to residents without staff present in that area, such as visitors' bathrooms, be equipped with single hand motion locks on the inside, particularly if there are residents who are disoriented or suffering from dementia in the home.

24. **Question:** Is permissible for adult care home residents to use electric blankets, if they so desire?

Answer: Adult care home residents may use electric blankets, if they so desire. However, the blankets must be UL listed, in good condition, properly cared for per their instructions (no dry cleaning), oxygen is not in use, and their use is not restricted by the local fire Marshall.

25. **Question:** Is there a limit to the number of family members who may sleep in the staff bedroom? Is there an age when a child must have his own room rather than sleeping with his/her parents in the staff bedroom?

Answer: The intent of Rule 13G .0307 is to ensure sufficient and appropriate bedroom space for residents of the adult care home. Square footage and other bedroom requirements apply to resident bedrooms, that is, bedrooms of those persons the home is licensed to serve and protect.

Adult care home rules set minimum rules to safeguard and promote the health, safety, well-being, rights and dignity of each resident. The rule should not be used for the purpose of regulating private family sleeping arrangements within the home, just as the State does not regulate such arrangements in any residence. If the arrangement does not prevent compliance with space requirements for the clients/residents or does not negatively impact their health, safety, well-being, rights and dignity, the regulatory agency does not have the right to make life-style value judgments to dictate bedroom space needs for live-in family members. The rule is to be applied in the regulatory context for which it is intended, that of protection of residents subject to the services and care for which the home is licensed.

26. **Question:** Can a non-resident husband or wife live with his/her spouse who is an adult care home resident? Is this 24 hour visitation for an indefinite period of time allowed?

Answer: Licensure rules do not prohibit this practice. If the non-resident spouse was receiving any personal care or services for which the home was being paid, he/she would have to be admitted as a resident of the home. Bedroom space would need to be sufficient for two persons as specified in 13G .0307(d). If the bedroom is designated as a resident bedroom and approved for only one person based on square footage requirements for resident bedrooms, the non-resident spouse cannot be an occupant of the bedroom. The resident must be assured of at least 80 square feet per bed, excluding vestibule, closet, or wardrobe space.

27. **Question:** Can live-in staff members use portable heaters in a family care home if the heaters are only used in the staff members' living quarters?

Answer: Licensure Rule 13G .0316(b) states that portable fuel burning and electric heaters are prohibited in family care homes. A distinction is not made between family and resident living quarters. The rule applies to the building. The use of these devices increases risk of fire and cannot be allowed in settings that house and serve a vulnerable and disabled population.

28. **Question:** Is it permissible for adult care homes to use bunk beds if the home has younger residents who request bunk beds?

Answer: Adult Care Home Licensure rule 13G .0314(c)(1) specifies the use of single or double beds, neither of which indicates the use of a bunk bed. The safety factor must be emphasized in settings in which a vulnerable population is being supervised and cared for. Bunk beds, while not necessarily a safety threat, do present enough of a safety risk through greater potential for injurious falls and even collapse of the top bed to make their use inappropriate in a protective environment like an adult care home, despite the fact that it is younger residents who would like to use them. If it is the case that the residents would be

**North Carolina Department of Health and Human Services
Rule Interpretations**

Building, Fire Safety, and other Requirements

Section 300

asked to sign a disclaimer statement not holding the home responsible for any accident resulting from the bunk bed use, there is clear indication and awareness of the risk involved.

29. **Question:** Are privacy curtains or partitions required for urinals in adult care home bathrooms?

Answer: Bathrooms must be designed to provide privacy. While the rule does not specifically make reference to urinals, the degree of privacy indicated by the requirement to separate toilets, tubs, and showers through the use of partition or curtains clearly indicates the need to provide a privacy partition or curtain between the urinal and commode. A privacy partition or curtain is required for a urinal in an adult care home bathroom.

30. **Question:** Is a family care home required to have a washing machine and dryer?

Answer: Rule 13G .0312 requires that laundry equipment not be located in certain areas of a family care home. It should be inferred from this rule that a family care home have the necessary laundry equipment, a washer and dryer, for the residents' laundry service. If a home is to have the equipment, it must be able to be used. An intent of the rule, therefore, is that family care homes have operable and useable laundry equipment. Even if laundry services are contracted, the home needs to have the ability to do laundry to ensure that laundry services are always available to the residents.

31. **Question:** Do family care homes licensed prior to 1977 have to meet the requirement that smoke detectors be wired directly to the house electrical current and that cooking units in kitchens be mechanically ventilated to the outside?

Answer: Family care homes licensed prior to 1977 are not required to have smoke detectors directly wired to the house current nor are the required to have cooking units mechanically ventilated to the outside. These homes are required to meet the State Building Code in effect at the time they were licensed and were determined to be safe under that existing State Building Code. Prior to 1977, the State Building Code allowed for plug-in and battery type smoke detector units and for cooking units in kitchens which were not mechanically ventilated to the outside.

32. **Question:** Is it permissible for a garage to be designated as an inside smoking area?

Answer: This is not acceptable because a garage is not considered a habitable space and would not be recognized as an area of the home. Only habitable space can be designated as an inside smoking area. However, if the home's policy does not allow smoking inside the home, nothing would prohibit residents from smoking in the garage area unless designated unsafe for that purpose by a fire marshall or building inspector. The N.C. State Building Code defines habitable space as a structure for living, sleeping, eating, or cooking. The code further states that bathrooms, toilet compartments, closets, halls, storage or utility space and similar areas are not considered habitable spaces. To ensure that a designated smoking area is in compliance with the relevant state and federal laws and rules, the local building inspector or fire marshall should be consulted.

33. **Question:** What constitutes an appropriate fire rehearsal?

Answer: There are no directives within adult care licensure rules regarding what constitutes an appropriate fire rehearsal. The rehearsals are to assure that staff are familiar with evacuation plans and other procedures to be followed in case of fire as specified in the home's fire/disaster plan. Fire rehearsals in most settings typically involve evacuation though guidelines for health care settings state that movement of infirm or bed-ridden patients is not required. A fire rehearsal is a simulation process and staff demonstration of knowledge and ability to act in an emergency is the goal.

Since the rules are not prescriptive as to evacuation of residents during fire rehearsals but do require the fire/disaster plan to be approved by the local fire safety authority, the home should consult with the fire marshal in establishing appropriate rehearsal plans. At least one of the quarterly fire rehearsals per year (one on each shift per year for an adult care home of 7 or more beds) should involve actual movement of residents to safe areas so that staff can demonstrate implementation of this procedure.

34. **Question:** Does a home have to meet Residential Care Facilities Section of the building code if it has residents who are normally ambulatory, but temporarily require crutches or a walker?

Answer: The use of crutches, a cane or a walker would not automatically require structural changes to the home. The certification by a physician that a resident requires supervision or personal assistance for a safe evacuation in an emergency is the basis for making structural changes indicated in the rules. Close monitoring is required should the conditions be changed by the resident's physician from a temporary to a permanent status.

35. **Question:** What is the facility's accountability when local inspectors fail to perform inspections of adult care homes as required by rule?

Answer: Local fire, building and sanitation inspectors sometimes fail to perform inspections in a timely manner for a variety of reasons. The most often stated reason is a lack of needed staff. We ask the facilities that are affected by this problem to document in writing their attempts to have these inspections completed. This documentation can include dates of telephone calls and copies of letters requesting the inspections. The adult home specialist should review these documents and can contact the inspectors if needed to verify these attempts. If this documentation is in the facility, the adult home specialist should not site the facility, but should work with the facility and the local inspectors to have the inspections completed.

36. **Question:** Do paper towels meet the requirement of the home having an adequate supply of clean towels and washcloths and a clean towel and washcloth in each bedroom for each resident?

**North Carolina Department of Health and Human Services
Rule Interpretations**

Building, Fire Safety, and other Requirements

Section 300

Answer: The intent of the rule is that each resident have a cloth towel and washcloth in his/her bedroom immediately available for his/her use. The exceptions to this requirement are for resident preference, as long as the towel and washcloth can be supplied when requested or needed, and for cases in which residents are consistently unable or unwilling to use these furnishings appropriately, such as trying to dispose of them or keeping them in an unsanitary manner, evidence of which should be documented in the resident's record.

37. **Question:** If residents choose to furnish their own rooms, are they mandated to have all of the required furnishings?

Answer: If a resident wishes to furnish his/her own room but does not want all of the required furnishings, the resident agreement or some piece of documentation on file would need to indicate that. This would not present a problem from a regulatory perspective as long as there was evidence that it was according to the resident's wishes and any furnishings used or not used did not negatively impact in any way the health and safety of the resident.

38. **Question:** Can a family care home be a special care unit for Alzheimer's residents?

Answer: The difficulty may be with meeting building codes for persons who are not able to self evacuate because of physical or mental disabilities. There are no provisions (allowances in the building code) for special locking arrangements to help prevent escape. Only institutional facilities can do that (maybe a 12 bed 419.5 compliant could have special locking) but not 6 beds. If a family care home were to be built to institutional occupancy, then it could be possible but probably cost prohibitive.

39. **Question:** Can an administrator use "call waiting" instead of an intercom system or line between an adult care home and the administrator's private home?

Answer: An intercom system or line enable the administrator to be immediately available to the home as required. Immediate availability is not provided by a "call waiting" telephone system. The administrator's telephone line could be tied up by another incoming call thereby restricting immediate contact with the administrator. Direct and immediate accessibility to the administrator is of utmost importance in emergency situations and would be compromised by having a "call waiting" instead of an intercom arrangement.

40. **Question:** Is it permissible for emergency/fire exits to lead into enclosed courtyards?

Answer: If an adult care home has an emergency/fire exit leading into an enclosed courtyard, there must be an accepted area of refuge for evacuees to gather and this area must be at least 50 feet of easy, direct access from the building. Therefore, the courtyard must be large enough in area to accommodate the 50-ft distance and the refuge area which should allow for approximately seven square feet per evacuee (this should be based on total population that would need to be evacuated). Otherwise, the gates leading from the courtyard would need to have the same type of locking system as on any other emergency/fire exit door leading from the facility. In addition, it is advised that the fire

**North Carolina Department of Health and Human Services
Rule Interpretations**

Building, Fire Safety, and other Requirements

Section 300

marshal be consulted wince determining what may be required to assure resident safety depends on the specific site. The fire marshal, in conjunction with DFS if necessary, can then specify what, if anything, needs to be done to make the area an appropriately safe one.

41. **Question:** Can a mobile home or a modular home be licensed as a family care home?

Answer: People have to be very careful about the terminology when discussing “mobile,” “manufactured,” and “modular.” The home must meet “the applicable requirements of the North Carolina State Building Code in force at the time of initial licensure.” Basically, “mobile” or “manufactured” homes do not meet the North Carolina State Building Code, but are only required to meet Federal HUD Standards. Therefore, they are not allowed to be a licensed Family Care Home. However, a “modular” home is built off site and shipped/assembled on the lot, but is required to meet the North Carolina State Building Code the same as if it had been site built. We have had some people state that their building is a “modular” home and then during our site visit, we have found that it really was a “mobile” or “manufactured” home. Either of these types of homes should have some form of a sticker identifying what requirements it meets.

**North Carolina Department of Health and Human Services
Rule Interpretations**

Charges/Cost of Care

Section 400

1. **Question:** May the administrator impose a charge for physician-ordered thickening agents that are added to a resident's food provided the charge is not deducted from the resident's personal funds?

Answer: If a physician orders a thickening agent such as Thick-it to be added to a resident's food, it becomes an essential, required part of the resident's diet. If a resident receives SA, that payment is for room and board which includes a resident's diet, regular or modified. The SA resident should not be charged additionally for the additive to thicken food.

Whether a private pay resident can be charged for the thickening agent depends on the specificity of the resident's contract. A resident contract must specify rates for resident services and accommodations. If the resident is to be charged for a modified diet or any supplements or additives modifying a regular diet, the contract should so stipulate these costs or indicate that the resident is responsible for payment for supplements and additives so that the resident or responsible party can make a fully informed decision on placement based on basic rates for services, room and board and any other charges that might be incurred.

2. **Question:** May the administrator impose a charge for nutritional supplements as ordered by a physician provided the charge is not deducted from a resident's personal funds?

Answer: A dietary or nutritional supplement as ordered by a physician is a diet modification, and therefore constitutes part of a therapeutic diet. Again, SA payments to residents are for room and board which includes provision of meals, snacks, and anything that modifies a person's regular diet as ordered by a physician. Therefore, residents receiving SA, or their responsible persons, should not be required to make additional payments for supplements.

For private pay residents, the contract between the home and the resident or responsible party determines how the cost of a supplement is to be charged. If the basic rate for care and services includes three meals a day and snacks, modified diets would be included unless stated otherwise. The modified diet would include physician-ordered supplements which would then be covered under the basic rate or in any additional charges for modified diets as specified in the contract, unless the contract made it clear that the cost of the supplement is an additional charge to the cost of modified diets.

3. **Question:** Can a resident be made to pay for a meal out of his personal funds while out of the home on an outing or other activity planned by the home?

Answer: The resident cannot be expected to pay for a meal while out of the home during an outing or other planned activity that is part of the activity program provided by the home. If a resident chooses to eat a meal outside the home rather than eat the meal served in the home, he would be expected to pay his own bill where he has eaten.

4. **Question:** If a bank imposes a service charge to an adult care home for a non-interest bearing account established for residents' personal funds, can the home pass this service charge on to the residents?

**North Carolina Department of Health and Human Services
Rule Interpretations**

Charges/Cost of Care

Section 400

Answer: There is nothing in the adult care home rules to prohibit such a practice. However, since this is an additional cost to the resident, the resident or responsible person should be notified and agree to this arrangement, either through the resident contract or some other form of documentation. Because this is a regular monthly charge to the residents, the most appropriate means of making affected parties aware of this service cost to be passed on to the resident is the resident contract on admission or an amended contract.

5. **Question:** Can the cost of adult diapers be charged against the personal allowance of Special Assistance recipients?

Answer: Adult care homes are not prohibited by rule to charge SA or private pay residents for diapers. Charges may be applied to the personal funds of the SA resident. Families or responsible parties may be asked to help pay for the diapers. The contract should indicate these charges if the resident is incontinent and using diapers. The contract should indicate these charges if the resident is incontinent and using diapers on admission with continued use planned based on the resident assessment and care plan. If the resident becomes incontinent after admission and it affects the cost of care that can be passed on to the resident such as the regular use of diapers over an extended period of time, the resident or responsible person should be notified and the contract amended. It should be noted that protective sheets and absorbent pads as well as bedpans and urinals are to be made available as needed at no charge to the personal funds of SA residents.

However, diapers should not automatically be used as the only recourse to caring for an incontinent resident. Assisting residents with toileting and maintaining bowel and bladder continence is basic personal care. These tasks are now Medicaid reimbursable tasks in adult care homes with additional payment for residents requiring extensive assistance in toileting. Further, the resident care plan should address how the home plans to deal with a resident's incontinence with the goal of maintaining or regaining continence as indicated by these personal care tasks.

**North Carolina Department of Health and Human Services
Rule Interpretations**

Charges/Cost of Care

Section 400

6. **Question:** Can a resident's personal funds be used to purchase a geriatric chair?

Answer: It is the responsibility of the home to make geriatric chairs available as needed through any means other than to charge the expense to the personal funds of Special Assistance recipients. Geriatric chairs are considered to be durable medical equipment as are bedside commodes, walkers, and wheelchairs. If the administrator agrees to care for a resident and all resources explored have been unable to supply the geriatric chair, the home is responsible for providing the resident with equipment as needed.

7. **Question:** Does the practice of charging an "applicant fee," or non-refundable entrance fee, which reserves a bed at the home prior to admission and is separate from monthly fees paid for adult care, violate the minimum rules or Special Assistance policy?

Answer: This practice does not appear to violate any APA rules governing adult care if the home's written agreement specifies the fee and is signed by the administrator and the resident or his/her responsible person. This is a reasonable private business arrangement when the potential resident or someone acting on his behalf has clearly agreed to this. However, this practice is not in line with SA policy. SA policy is clear that rates for SA residents are not to exceed the established monthly SA rate. An application fee would be considered in excess of that rate. In addition, application fees, even if paid by family or responsible party, would be counted as income and thereby affect SA eligibility.

8. **Question:** Can a home charge to the residents' personal funds the cost of a bulk supply of soap, shampoo, razors, etc., for distribution to use by any of the residents as needed.

Answer: No. Residents have the right to receive their own personal items from the expenditure of their personal funds. The home may buy the items in bulk and charge the resident for the items they use, but the policy of having residents pay from personal funds for a bulk supply of toiletry items for "community" use is in violation of Residents' Right #1: "to be treated with respect, consideration, and full recognition of his or her individuality..." This includes the resident's right to acquire personal items of his/her choice by whatever means he/she so chooses, whether through family, the home or direct purchase from a vendor and to not have to pay for items he/she does not use or chooses not to use.

9. **Question:** Whose responsibility is it to purchase personal care items such as shampoo, toothpaste, and deodorant? Must the home purchase these items or is it to come out of the resident's personal funds?

Answer: The home is not required to pay for shampoo, toothpaste or deodorant for residents. The purchase of these items is the responsibility of the resident or responsible person, and the home may charge the cost to the resident's personal funds unless the resident contract specifies otherwise.

Note: Bath soap and toilet tissue are essential hygienic items that are among the basic supplies a facility should be providing at no additional charge. The licensure rules do not

North Carolina Department of Health and Human Services
Rule Interpretations

Charges/Cost of Care

Section 400

provide an exhaustive list of items for which residents can or can't be charged additionally. It is a clear and reasonable expectation/assumption that soap and toilet tissue are not items that the resident must expend personal funds for.

10. **Question:** Is it permissible for an adult care home to structure its contract so as to have two separate pricing structures, one furnished and one unfurnished?

Answer: There are no restrictions per licensure rule on the “structuring” of the resident contract for private pay residents. The costs associated with residency in the home be specified in the contract. The intent is that prospective residents/responsible persons have full disclosure of cost of care. The rules do not prohibit, implicitly or explicitly, furnished and unfurnished room rates or the renting of furniture to private pay residents. The home must assure that the necessary furnishings are provided and that the contract specifies costs associated with provision of furniture if not included in the basic rate.

11. **Question:** Can an adult care home have a variable pricing structure for cost of care depending on estimated amount of personal care needed?

Answer: Adult care home licensure rules do not address pricing structures or systems other than prohibiting additional charges for certain items and services. Of course, Special Assistance is regulated, but the primary regulator of cost of care for private pay residents is the market. It is true that Medicaid reimburses for one hour of personal care per day, but that is strictly Medicaid reimbursement policy which specifies a certain amount per day based on an average of one hour of personal care per day according to cost model statistics. If the home clearly reveals its pricing structure in its contract with the residents including services available on each level, staffs at least to minimum staffing requirements, and provides the services residents need based on assessments, it is not out of regulatory compliance in using the variable pricing structure.

12. **Question:** Is it permissible for adult care homes to move Medicaid residents out of private rooms into semi-private rooms to accommodate private pay residents desiring private rooms?

Answer: If a Medicaid resident or his/her responsible party was assured of a permanent private room assignment, there would need to be a documented contractual agreement to that effect. In the absence of anything in writing with signatures indicating otherwise, the home can be expected to follow its established policy on room assignment.

13. **Question:** If an SA resident moves out of an adult care home, can the home refuse to refund cost of care in order to pay for property damage caused by the resident?

Answer: No. SThe resident's personal funds, however, may be used to pay for damages if the home has addressed the responsibility of the resident's payment for damages appropriately in its policies.

**North Carolina Department of Health and Human Services
Rule Interpretations**

Charges/Cost of Care

Section 400

14. **Question:** Is it permissible for a home's refund policy to specify that no refunds for vacated rooms will be issued until all of the resident's personal belongings are completely removed from the home?

Answer: No. Refunds are to be made within specific time frames according to rules of settlement of cost of care. There are no allowances in the rule for extending that period of time.

15. **Question:** Can an adult care home charge private pay residents who receive the same services a different rate?

Answer: Private pay rates are set by the home and are not required to be the same for each resident. The rules do require a resident contract to be reviewed and signed by the resident or responsible person and a copy furnished to him or her. The contract must specify rates for services and accommodations. The resident or responsible person certainly has the right to have rates clarified or questions answered regarding charges. The resident's record must include a statement signed and dated indicating that the contract and other information on the home has been received.

16. **Question:** Is it permissible for an adult care home to charge residents for cleaning supplies and damages due to incontinence?

Answer: No. Any policy to that effect, whether stated specifically or implied in a reference to payment for damages in the resident agreement or discharge checklist, is inappropriate. Adult care homes are required by statute to provide personal care which includes "attending to any personal needs residents may be incapable of or unable to attend for themselves." This includes toileting and attending to the incontinence needs of residents. In addition, housekeeping service and supplies are basic provisions of the home which should be included in the monthly rate.

17. **Question:** Can a family member pay for a sitter to stay with an SA resident in an adult care home?

Answer: Yes. This arrangement would not effect SA if the arrangement is directly between the family member and sitter with no money for such purposes applied to the resident's account in the home. The arrangement should be strictly on a privately contracted basis. On the other hand, an additional fee paid to the home to arrange for a sitter is not allowed since it would be considered a gratuity in addition to established rates which is prohibited in rule.

18. **Question:** When a resident, who receives Special Assistance, moves from one home to another, may the Special Assistance refund be used to pay outstanding medical bills at the first home?

Answer: No. The refund which the resident has received is for settlement of cost of care at the former home and is to be used for payment of cost of care at the new home for the

**North Carolina Department of Health and Human Services
Rule Interpretations**

Charges/Cost of Care

Section 400

remainder of the month after the move has taken place. The SA money refunded to the resident for settlement of cost of care are not a resource to be used by the home for payment of these other expenses, including medical expenses.

19. **Question:** May an administrator deduct money owed to the home from the residents' personal funds before disbursing the personal funds to the resident?

Answer: Whether a transaction occurred before or after disbursement of the personal funds to the resident would not be of any consequence as long as the transaction was recorded by the administrator and signed by the resident.

20. **Question:** Once the resident gives the management of the home written permission to handle personal funds, can the administrator or designated person set the rate of disbursement of these funds? Should the resident automatically be given the full amount of the personal funds minus any bills incurred?

Answer: Adult Care Home residents have the same legal rights to manage their financial affairs as persons living in other settings. A resident may choose to delegate this responsibility to the administrator. Once the administrator accepts delegation of handling a resident's personal funds, it is expected that disbursement and receipt of money be done in an appropriate manner and in accordance with the adult care home rules, which require proper written accounting of all receipts and disbursements. The extent of the resident's delegation may vary and should be in writing and signed by both the administrator and the resident. Generally, the personal funds delegation is total and in such situations the administrator has delegated authority to disburse the monthly personal funds allowance as he sees fit in order to satisfy the resident's financial obligations and personal needs. At any time the resident or guardian has the right to change or alter the personal funds delegation if necessary. Should the resident find the way that the administrator is administering his personal moneys allowance unsatisfactory or arbitrary, he has a right to obtain an accounting of his fund and specify changes in his written personal funds delegation. Nothing in the rules prohibit the resident from being specific as to the delegation as long as the home agrees to these specifics. Since it is the administrator's responsibility to handle the resident's personal funds finances, it would be proper to disburse money owed prior to giving the resident the balance as long as proper written accounting is made.

21. **Question:** Can an adult care home deduct the amount of a pharmacy bill from a resident's personal funds if the resident refuses to pay it?

Answer: Adult care home residents are assumed to have the same legal rights to manage their affairs, financial and otherwise, as persons living in other settings. This includes the right and responsibility to make choices about the payment of incurred bills. This right is expressed in the rules and in the Adult Care Home Residents' Bill of Rights. A resident may choose to delegate this responsibility to another person, or this responsibility may be removed from him/her through guardianship proceedings. In either situation, his/her right to manage personal funds is protected.

North Carolina Department of Health and Human Services
Rule Interpretations

Charges/Cost of Care

Section 400

For this reason, the rules require that the administrator have written authorization from the resident or his/her legal guardian or payee in order to handle his/her personal money. If the resident refuses to pay for necessary services (i.e., co-payments, non-Medicaid covered medications, etc.), the administrator, family/responsible person, or social worker should counsel the resident regarding the necessity of appropriate payment for these services, making sure he/she understands all the possible consequences of non-payment which could be discharge from the home. If the resident continues to refuse to cooperate, it may, in some instances, be appropriate to consider the competence of the resident, and discuss with the family the appropriateness of legal measures to protect him/her if necessary. Appropriate documentation of the efforts to resolve the problem should be maintained in the resident's record in the home.

22. **Question:** Is it permissible for an administrator of adult care homes located in different counties to deposit the personal funds of the residents into one non-interest bearing account?

Answer: A resident's personal funds cannot be commingled with the personal funds of other residents in an interest-bearing account set up by the administrator. The account in question here is a non-interest bearing account. The rules do not address separating different residents' personal moneys after the funds are deposited in a bank account. The rule does require an accurate accounting of moneys received and disbursed and that the balance on hand is available upon request of the resident and his/her legal guardian or payee. In addition, the administrator is to use a resident financial record in maintaining the account. The administrator would be meeting the intent of the rules regarding management of residents' personal funds in this type of situation.

23. **Question:** How much of a resident's personal funds can an administrator withhold from the resident to cover costs incurred?

Answer: If there is written authorization of the resident, legal guardian, or payee, the administrator can withhold the amount necessary out of the personal needs allowance to cover costs incurred by the resident that are not covered by SA and Medicaid or otherwise not allowed to be covered by personal funds. The remaining amount after these costs are covered and transactions documented according to rule is the balance that must be available to the resident. While it is preferable that a resident have some discretionary funds, there is nothing in rule that requires this if the administrator has authority to handle the funds, follows required accounting procedures and the resident agreement does not indicate otherwise. The resident may change the authorization at any time.

24. **Question:** Is it permissible for an adult care home administrator to require residents' Social Security checks to be mailed directly to the home for endorsement by the residents?

Answer: The administrator of an adult care home cannot require a resident's Social Security check to be mailed directly to the home. The rules clearly stipulate that the resident, legal guardian, payee, or other legally constituted authority is to manage funds. Since the administrator may not serve as one of these entities except in the case of being so authorized by the appropriate federal agency, the demand for direct receipt of the check is inappropriate.

**North Carolina Department of Health and Human Services
Rule Interpretations**

Charges/Cost of Care

Section 400

25. **Question:** May the cost of over-the-counter prescriptions be charged to the personal funds of SA residents?

Answer: Over-the-counter medications such as aspirin and antacids may be charged to the personal funds of the residents. Since there is no provision in the rules regarding responsibility for paying for routine, non-prescription medications, the administrator is not prohibited from imposing a charge for such items. The issue of payment should be discussed with the resident or his/her responsible person prior to or upon admission to the home. The Resident Register which includes plans for payment of various resident expenses must be completed and signed by the administrator or administrator/supervisor-in-charge and the resident or his/her responsible person.

The personal needs allowance for state-county special assistance recipients often does not cover all of the expenses for personal needs that a resident has. The personal needs allowance can easily be depleted by the purchase of items other than over-the-counter medications. While the administrator is not directly required to pay for these items, Rule 13F .0902 and 13G .0902 state "The administrator shall make arrangements with the resident, his responsible person, the county department of social services or other appropriate party for appropriate health care as needed to enable the resident to be in the best possible health condition." The adult care home administrator is ultimately responsible for seeing that the residents receive appropriate care. Therefore, when other resources have been exhausted or there is no other means of gaining financial or other assistance to meet the resident's health care needs, the administrator must assess the home's ability to provide adequate care to the resident.

26. **Question:** If an adult care home contracts with a barber/beautician to come into the home to cut a resident's hair for a certain price, can the home charge the resident a greater price?

Answer: There is nothing in rule regulating charges for optional services such as beautician/barber services. These services are not required in rule nor are residents required to purchase these services. This is a private business and consumer choice arrangement which is left up to home management, the beautician/barber and the decision of residents to use or not use the optional service.

27. **Question:** Is it possible for adult care homes to accept payments for room and board from a third party, in addition to the maximum rate established by the General Assembly, on behalf of State/County Special Assistance (SA) residents residing in the facility?

Answer: Yes, under the following conditions:

- The payment is made directly by the third party (family member, charity, church, etc.) to the facility. Money paid directly to the facility to supplement the cost of room and board

**North Carolina Department of Health and Human Services
Rule Interpretations**

Charges/Cost of Care

Section 400

under the conditions below will not be counted as income and will not affect SA eligibility or the SA payment amount.

- The payments made by the third party are made voluntarily and result in the added benefit of:
 - a. A private room is provided; or
 - b. A private or semi-private room in a special care unit is provided.
- Accepting payments from a third party on behalf of a SA recipient, where the SA recipient resides in a regular semi-private room, is not permitted
- Money given directly to the SA recipient, regardless of intent, is counted as income in determining SA eligibility and establishing SA payment amount.

28. **Question:** Can an adult care home charge a resident (SA or private pay) or his responsible person for gloves, incontinent cream, and wipes?

Answer: The resident contract must specify rates for services and accommodations and that any charges in service or care charges requires an amended contract to be reviewed and signed by the resident or responsible person. For private pay residents, the facility can itemize charges and thereby indicate charges for gloves, incontinent cream and wipes and any other items not covered under basic rate or monthly charge. The contract should disclose any additional costs in addition to a basic rate. Otherwise, it is reasonable to expect that the cost of these items is included in basic or monthly rates specified in the contract.

While the primary regulator of cost of care for private pay is the market, payments to indigent residents for room, board and care are regulated through public assistance and Medicaid. These residents also receive a personal needs allowance. However, gloves and wipes used by staff in performing personal care duties should not be considered a resident's personal needs allowance item. These are basic incontinence care items used for hygienic and infection control purposes. The facility may seek other payment sources but should not be charging the SA resident for these items or requiring payment from the responsible party.

29. **Question:** How should facilities handle refunds of security deposits?

Answer: There are no state laws or regulations dealing specifically with security deposits for adult care homes in north Carolina and refunds of such deposits. State rules do address time frames for refunds of cost of care. There must be written refund policies signed by the administrator with copies given to the resident or responsible party and filed in the residents' records. If a home charges a security deposit, its refund should be addressed in the home's refund policies.

30. **Question:** Can a facility establish base rates for private pay residents and then specify additional costs?

**North Carolina Department of Health and Human Services
Rule Interpretations**

Charges/Cost of Care

Section 400

Answer: Rates for services and accommodations must be specified in the adult care home's resident contract. For private pay residents, a facility can itemize charges, and in fact, must do so if all costs are not included in an all-inclusive monthly rate. The intent of the rule is that there be full disclosure and no hidden costs so that residents and their families know not only how much they will be paying but exactly what they will be paying for. Therefore, a facility is not prohibited from establishing a basic rate for private pay residents and specifying costs not included in the basic rate. The key is full disclosure so that, while private pay costs are market driven, individuals can make informed choices based on those costs.

31. **Question:** May a home have a policy of limiting disbursement of personal funds to \$100 on the day it is requested and providing the remainder of the requested the next day?

Answer: No. The balance of the resident's personal funds must be on hand and available upon request according to rules on personal funds. Requiring a resident to wait until the next day for requested funds does not meet the regulatory intent of this rule for adult care home residents to have ready access to their funds.

32. **Question:** Can residents be charged for 'sitter' fees at doctor's offices?

Answer: Private pay residents may be charged for 'sitter' fees at doctor's offices if this kind of additional charge is disclosed at admission in the resident agreement or contract. Disclosure is the key here. SA/Medicaid residents cannot be charged additionally for this service since rates charged to public assistance residents are to include all care and services for which the facility is licensed, including supervision, unless stipulated otherwise in licensure rule.

33. **Question:** May an adult care home charge an SA/Medicaid resident for a Wander-Guard bracelet or other device used for supervision/protection purposes?

Answer: No. Adult care homes are reimbursed by Medicaid for personal care, including supervision, of their SA/Medicaid residents. Assuring adequate supervision and protection of wandering residents is required by rule as part of the care and services provided to residents for which the home is reimbursed. The facility may choose to use a system such as Wander-Guard which can be very effective, but could not impose an additional charge on public assistance residents for its use just as it could not require residents to help cover the cost of door alarms.

34. **Question:** Can an SA resident pay more than the established SA rate for adult care home room, board and services?

Answer: The maximum rate to be charged to public assistance residents (SA) is that established by the Social Services Commission and the General Assembly. That is the SA rate paid to eligible residents. Any additional payment as established in the resident contract

**North Carolina Department of Health and Human Services
Rule Interpretations**

Charges/Cost of Care

Section 400

is not allowed. Other additional payments would be considered gratuities which are prohibited. In addition, to these prohibitions, the Public Assistance Section of the Division of Social Services has stated that additional payments will affect resident eligibility. (See #28 regarding additional payments for private rooms.)

35. **Question:** What does an “additional fee for laundry services are prohibited by rule” mean?

Answer: For a private pay resident, what an “additional” charge/fee is depends on the contract. Some facilities will itemize charges and as long as it is disclosed in the contract that there is a laundry charge, this is not an additional charge. If the contract specifies a monthly rate for care and services and does not indicate specific charges for laundry or other services, charging the resident a fee for laundry is an additional fee, i.e., in addition to what the resident had agreed to pay according to the contract. This is not allowed by rule. SA residents cannot be charged any additional fee since the cost for care, services and accommodations is covered by SA and Medicaid payments. Private pay residents are being charged for laundry, whether it is up front in a specific charge as may be stated in the contract or included in a flat monthly rate for cost of care and services. “Additional” in the context of the rule means in addition to the established rate or cost. For public assistance residents, that rate is established in SA and Medicaid payments. For private pay residents, it is established in the contract.

36. **Question:** As indicated by Rule 13G .0314(a)(7) , the administrator of a licensed home must make available through any means other than charge to the personal funds of recipients of State-County Special Assistance personal care items such as “protective sheets and clean, absorbent soft and smooth pads.” May the administrator impose a charge on the residents or their families for these items provided the charge is not deducted from the resident’s personal funds?

Answer: By admitting or choosing to keep an incontinent resident, the administrator must “make available” through any means, other than a charge to the personal funds of a resident receiving State-County Special Assistance (SA) personal care items, such as protective sheets and clean absorbent soft and smooth pads, which are necessary to care for the incontinent resident. Ideally, the care of the incontinent resident would also include a routine toileting schedule aimed at reducing the need for these particular personal care items.

Administrators can meet his requirement in various ways, each of which may be acceptable. First, a private paying (non-SA) resident or any resident’s family or responsible person may be asked to provide these items. If the home elects to charge a non-SA resident or any resident’s family or responsible person for these items, this charge should be specified in the resident’s contract. It is recommended that the resident or his/her family or responsible person request an itemized account of supplies furnished. Second, community resources, including the county DSS, may also be of assistance in acquiring specific items. Third, the home may elect to provide these items at no charge. In any event, if the administrator agrees to care for a resident and all resources explored have been unable to supply the needed item(s), the administrator is ultimately responsible for providing the resident the personal care item.

North Carolina Department of Health and Human Services
Rule Interpretations

Food Service

Section 500

1. **Question:** Do the adult care home rules designate specific temperatures to be maintained in a home's refrigerator and freezer? Can a home be cited for failing to maintain certain temperatures in the refrigerator or freezer?

Answer: Maximum refrigerator and freezer temperatures are sanitation requirements enforced by local sanitation inspectors from the county health department and are not specified in adult care home licensure rules. Licensure rules do state that the home has to be in compliance with sanitation regulations. The sanitation report is, of course, indicative of compliance; however, if there is a question or concern about the home continuing to meet these regulations during the year, the county sanitarian should be contacted regarding certain requirements. If a home is to be cited for violation of a rule requiring the home to be in compliance with another set of regulations, the source or enforcer of those particular regulations needs to be consulted regarding current requirements to verify that the home is indeed not meeting the regulations referenced in licensure rules. A home can be cited for failure to maintain appropriate refrigerator and freezer temperatures as required in the sanitation rules and failure to do so violates 13F .0904(a)(2) and 13G .0904(a)(2), which require food be protected from contamination.

2. **Question:** Can residents on modified diets be served a "managers special" meal in which food chosen by the residents is served?

Answer: A doctor's order for modified diets must be followed whether or not there is a "manager's special." Any exceptions must be made in consultation and agreement with the resident's physician. This contact and decision should be documented in the resident's record.

3. **Question:** What is the home's responsibility in assuring that residents on modified diets follow those diets when eating meals or snacks out of the home?

Answer: The home cannot assure that a resident follow his/her diet when out of the home. In addition, the home cannot control the choices a resident may make at vending machines in the home. Mediating between the residents' rights and the home's responsibility for the health, safety and welfare of the residents can be difficult. Confused residents may not have the capacity to make decisions about their diet and this should be considered in dealing with this issue. In any case, the resident's physician should be notified of any resident's persistent noncompliance to a therapeutic diet and the noncompliance and any communication to the physician documented in the resident's record. If the physician will not agree to liberalize or change the diet order to the resident's wishes, it can be assumed that the diet is needed to maintain the health of the resident. Ultimately, however, the resident has the right to make his/her own decisions unless adjudicated incompetent.

4. **Question:** Do rules for adult care homes prohibit staff from cleaning rooms while food carts are on the hall?

**North Carolina Department of Health and Human Services
Rule Interpretations**

Food Service

Section 500

Answer: No. Rule .0904(a)(2) requires that food be protected from contamination while being served. Resident rooms must not be cleaned while residents are eating in their rooms. There must be no strong odors from the cleaning agents that are offensive to residents while eating and sufficient staff must be available for serving food and for cleaning.

5. **Question:** Can leftovers be served at meals?

Answer: Adult care home licensure rules on food service do not prohibit the use of leftovers. Of course, any food served must be protected from spoilage and contamination. It is recommended that a dietitian or the local health department be consulted for guidance in assuring protection of the leftovers and serving them within an appropriate time frame. A “rule of thumb” is that leftover foods be served within three days of preparation unless preserved through freezing, assuming appropriate holding temperatures were maintained and the leftovers were cooled down in appropriate containers.

6. **Question:** Can prepared egg products be used in place of eggs in adult care facilities?

Answer: If a facility chooses to use prepared egg products, it must be a whole egg product that is comparable in nutritional value. Egg white products, such as “Eggbeaters” are not comparable in nutritional value. Regular eggs should be served if residents do not find the prepared egg product to be palatable.

7. **Question:** If residents prefer juices like Bright and Early, Sunny Delight or 5 Alive, can these juices be substituted for a citrus fruit since they are fortified with Vitamin C?

Answer: The term “single strength,” is used by USFDA to indicate what may be labeled or advertised as juice. It means 100% fruit juice. The rules use that term accordingly to mean that the substitute for the citrus fruit must constitute 100% fruit juice. Therefore, juice drinks like Bright and Early, Sunny Delight, and 5 Alive, which are not 100% fruit juice, cannot be used as the substitute. The intent is not just that the substitute contain the necessary vitamin C requirement, but that the substitute be as healthy by being as close to the equivalent of citrus fruit or fresh juice as possible. This does not mean that juice drinks cannot be served to residents. They just cannot be used as the substitute for the daily fruit serving requirement.

8. **Question:** Do the rules prohibit food for live-in staff and residents from being on the same receipt?

Answer: State rules do not require separate food receipts for live-in staff and residents. Rules do specify the keeping of invoices or other appropriate receipts. The intent is that there be a record of how much food is purchased to assure that sufficient quantities of food are available to feed the residents based on menu requirements and the number of people being fed from the purchased food. While keeping separate receipts might facilitate

North Carolina Department of Health and Human Services
Rule Interpretations

Food Service

Section 500

monitoring and compliance with food service requirements and may certainly be encouraged, it cannot be enforced as a rule.

9. **Question:** When residents participate in a day placement or employment program on a regular basis, what is the home's responsibility for providing breakfast, lunch supper and snacks to the residents while they are away from the home at the day placement or employment?

Answer: The rules specify that adult care homes have the responsibility of providing to all residents three meals a day and snacks. This is one of the services that should be covered in the home's residents contract specifying rates for services and accommodations, which means the home is being paid for the food service. Also, day/work programs are normally a part of required or prescribed treatment, therapeutic, or rehabilitative program for certain eligible residents. The fact that these residents are not routinely in the home at the regular meal times does not free the home from its responsibility of food service to the residents.

10. **Question:** When residents eat out of the home, what should be posted on the menu?

Answer: If it is planned or a scheduled event, then the planned menu or substitution log should indicate this for that particular meal. If it is unplanned (e.g., decision made to eat lunch at mall on group shopping trip), then this should be noted as a substitute for the meal upon returning home.

11. **Question:** When there is a cluster of family care homes and food is prepared in one home for all homes, must there be a current menu in each home? Must there be a substitution list in each home with substitutions recorded prior to serving food? Must the kitchen being used to prepare all of the food meet additional requirements?

Answer: Rule .0904 requires that menus be "identified" in the kitchen for the guidance of food service staff. The menu, as well as any substitution list, is required to be documented in the kitchen where the food is prepared. Since the menu must specify serving quantities, it must have any substitutions documented in the kitchen from which the food is also served.

The menu is a guide for the preparing and serving of food. Therefore, if the food is cooked and plates prepared with appropriate servings for each resident in one kitchen to be served directly to residents in the other homes, then the menu and substitution list need only be available in that one kitchen. However, if food is cooked in one kitchen and plates are prepared and served from kitchens in the other homes, then menu guidance is necessary in those homes as well. The menu provides guidance as to what is served and how much is to be served to each resident and thus must be current and available in any kitchen where those duties are performed.

The important thing to remember in using one family care home kitchen to prepare meals for all the residents in a cluster of family care homes is the total number of residents served since it is this number that determines the classification status of the kitchen. In family care homes

**North Carolina Department of Health and Human Services
Rule Interpretations**

Food Service

Section 500

in which food is prepared for more than 12 residents, the sanitation rules for an institutional kitchen apply.

12. **Question:** Is it a rule violation for an adult care home to have a policy or house rule which prohibits the serving of pork based on religious preferences of the administrator?

Answer: Rule .0904(c)(4) states, “Menus shall be planned to take into account the food preferences and customs of the residents.” If the facility chooses to not serve certain foods because of the facility’s preferences, the facility should have written policies available for residents upon admission that indicates their system. Regardless of facility policies, the menus would have to meet licensure daily food requirements, be nutritionally adequate and planned to take into account food preferences of the residents.

13. **Question:** Do the rules allow the dining service to be a separate department operating independently from the home with supervision separate from the administration/management of the home?

Answer: There is nothing in the rules that would prevent an adult care home from establishing a centralized food service operation to serve the home’s residents and the various other programs/activities that are a part of the total organization. In establishing this type of operation, the administrator must still comply with all of the food service regulations outlined in the rules as well as the regulations for food service personnel. The preparation and serving of food, menu planning, daily food service, and the qualifications for food service personnel are subject to monitoring by the adult home specialist from the county department of social services as well as to periodic review by local sanitarians. The administrator is responsible for the total operation of the home, which includes its food service operation.

14. **Question:** Are combination menus required for combination diet orders?

Answer: Combination diet orders that consist of two or more diets that require a therapeutic diet menu shall have a specific combination menu for the combined therapeutic diets ordered (e.g., 1800 ADA 2 gram Sodium). The exception would be if one of a combination of two therapeutic diets were a consistency-modified diet (e.g. 1800 ADA Mechanical Soft). For this exception, the facility shall have both therapeutic diet menus signed by a registered dietitian. The food service staff shall provide the appropriate food items from the first therapeutic diet menu with the proper mechanical alterations made using the mechanically altered diet menu for guidance. Whenever possible, the resident’s physicians should be contacted to obtain a simplified diet order that will meet the resident’s needs.

15. **Question:** May adult care homes use home canned fruits or vegetables?

Answer: Our food service rule does not address home canned foods; however, Rule .0904(a)(2) states “All food and beverage being procured, stored, prepared, or served by the

**North Carolina Department of Health and Human Services
Rule Interpretations**

Food Service

Section 500

facility shall be protected from contamination.” Sanitation rules would be referred to for this answer. Sanitation rules for homes with more than 12 beds do not allow for home canned foods as stated in 15 NCAC 18A .1321 Food Supplies. This rule refers to 15! NCAC 18A .2600, which says foods, have to be processed in a commercial food-processing establishment. Sanitation rules do not prohibit the use of home canned foods in homes with 12 beds or less; however, the use of home canned foods is discouraged because of the risk of botulism

16. **Question:** Should fiber supplements be classified as dietary/food/nutritional supplements which have been interpreted for adult care home purposes as being part of a modified diet if ordered by a doctor and, therefore, not subject to additional charge to the resident?

Answer: Most fiber supplements are intended for use as laxative therapy and, if so ordered, should not be considered as a dietary, i.e., food/nutritional supplement which is ordered for consumption as a food (solid or liquid) for nutritional purposes. While some fiber supplements may be classified by the manufacturer as dietary supplements, they are essentially and primarily constipation remedies. Therefore, for the purpose of “interpreting the interpretation” and its application to adult care homes, fiber supplements are not be interpreted as a dietary supplement. The more appropriate classification would be “over the counter” medication.

17. **Question:** How can it be determined what an adequate serving size of a meat product is to meet the 2-oz protein requirement in adult care homes?

Answer: One ounce of pure meat is equal to 7 grams of protein; thus, two ounces of meat would equal 14 grams of protein. When using a meat product (i.e., hot dogs, bologna, fish sticks, chicken patties and/or nuggets, pot pies, soups, etc) determination of the serving size required to meet the protein requirement is based on how much of the product it takes to equal 14 grams of protein. Items such as dried legumes (beans), cheeses, and nut butters can be used to bring the total protein of the lunch or dinner meal up to 14 grams.

18. **Question:** What are “feeding techniques for residents with swallowing problems” as stated in Rule .0903?

Answer: These are any specific directions from a resident’s physician or licensed health practitioner which may require a special device or manipulation to facilitate or enable the ingestion of food by the resident, e.g. head tilt, chin tucks, or positioning.

19. **Question:** Can pie crust, cake, and cookies count as part of the grain/cereal/bread requirement in Rule .0908(d)(3)(f)?

Answer: Yes. The caloric and nutritional needs of residents would most likely still be met since grain is a component of these items. Menus can be evaluated on an individual basis for adequacy if this becomes a concern.

North Carolina Department of Health and Human Services
Rule Interpretations

Forms/Records

Section 600

1. **Question:** Is an adult care home resident who has a rehabilitative stay in a nursing home and a bed hold agreement with the adult care home to be considered as discharged and a new admission when returning to the adult care home since level of care changes are involved?

Answer: No. This situation should be considered the same as a hospital admission when there is documentation that the resident was admitted to the nursing home for rehabilitation purposes and not officially discharged from the home.

2. **Question:** If adult care homes have employees of private staffing agencies with which they have contracts providing personal care, food service and medication administration, and the contract with the private staffing agency states that the employees' qualifications satisfy all state requirements, are the homes required to keep file documentation on site for temporary employees that would verify that required minimum qualifications are met?

Answer: Yes, there must be documentation within the home that staff meet the personnel requirements as specified in rule. Rules specifically state that there is to be documentation on file in the home. Whether or not staff are directly employed by the home, the home is directly responsible for assuring that staff, temporary or not, meet the necessary qualifications and for maintaining records for verification by the regulatory and monitoring agencies. Appropriate verification is not a compliance statement by the staffing agency just as it is not a compliance statement by the home's administrator. The monitoring agent should not have to monitor the home's compliance with personnel requirements at the staffing agency site.

3. **Question:** Do personnel files need to be maintained in the adult care home or can they be on file in a central office location?

Answer: At least a copy of the following personnel information needs to be maintained within the home for review by the monitoring agent. Other information as stated in rule can be in another location but must be made available for review on request by the monitoring agent.

- documentation of qualifications for administrator, administrator-in-charge, supervisor-in-charge, and supervisors
- documentation that staff are free from tuberculosis in a communicable stage;
- a detailed job description for each staff member, signed by the administrator and the employee;
- documentation of training in cardio-pulmonary resuscitation and choking management;
- documentation of successful completion of personal care training or competency evaluation for exemption from the training; and
- notification of where (address and telephone number) complete personnel files are maintained.

**North Carolina Department of Health and Human Services
Rule Interpretations**

Forms/Records

Section 600

- Medication skills validation and certificate of completion of the medication exam
- Licensed Health Professional Support skills validation

4. **Question:** Rule 13F/G .0902 state that there must be written instructions as to what to do in case of sudden illness, accident or death of an adult care home resident. What should these instructions include?

Answer: These written instructions should include at least the following:

- who to contact immediately in the home;
- plans for notification of physician, EMS, responsible party, and the coroner in case of death of the resident. Include all telephone numbers with instructions. The physician or EMS should be contacted as soon as possible unless accident is minor and can be treated with first aid. If in doubt, get medical attention as soon as possible;
- procedure for making report of accident or incident;
- plans for assuring that the resident is not left alone and monitored closely until medical help arrives.

5. **Question:** Must the results of a resident's TB test be entered on the FL-2?

Answer: The results of an adult care home resident's TB test can be in the FL-2, MR-2, attached to these forms or otherwise included in the resident's file where medical information is kept. What is important is that there be documentation of TB test results on file. In what form the results are on file, as long as they are readily accessible, is not significant regarding fulfillment of the intent of the rule.

6. **Question:** Can resident records temporarily be removed from a family care home for review and record keeping purposes if the medical records are filed separately and remain in the family care home?

Answer: In the sections concerning resident records, there is no prohibition to the temporary removal of the residents' records for business purposes. Under such situations, the records should continue to be accessible for monitoring and licensure staff. It should, also, clearly be a temporary arrangement, and the records should be housed routinely in the family care home. A notice should be posted in the family care home giving the temporary location of the records.

7. **Question:** Can a stamped doctor's signature be used on a faxed doctor's order or a restraint order on a home's form?

Answer: According to the North Carolina Board of Medical Examiners, there is no current law governing the use of signature stamps by physicians. These signature stamps are used by physicians for convenience and may be used on any form kept in an adult care home

**North Carolina Department of Health and Human Services
Rule Interpretations**

Forms/Records

Section 600

requiring a physician's signature, including faxed orders. However, if it is suspected or if it is known that the home's personnel are using a physician's signature stamp to falsify records, the North Carolina Board of Medical Examiners may be contacted for investigations or the North Carolina Board of Nursing if a licensed nurse is involved.

Electronic signatures are also acceptable. The document must state that this is "an electronic signature for" and give the physician's name. For example on a discharge report from the hospital that has medication orders there must be documentation that "This is an electronic for—(MD NAME)".

8. **Question:** Can facilities refuse to share documents such as shift notes with regulators?

Answer: General Statute 131D –2 (b)(4)a states: "Department representatives may review any writing or other record concerning the admission, discharge, medication, care, medical condition, or history of any person who is or has been a resident of the facility being inspected..." This law does not limit review to records required by rule or law since it clearly states "any writing or other record..." without qualification. Therefore, the law is clear in its language and intent and requires no further interpretation. While the adult care home may be a private business, it is subject to the laws and rules of the state established to assure that the health, safety and rights of residents are protected. It is not unreasonable that any documents or written material addressing these factors be subject to regulatory review as needed, including shift notes.

9. **Question:** Do the criminal history record checks, as required by G.S. 131D-40, have to be done by the state?

Answer: No. G.S. 131D-40(a) states that an adult care home shall submit a request to the Department of Justice to conduct a criminal history record check of the applicant employee. The General Statute was amended to include a facility could "submit a request to a private entity to conduct a State criminal history record check". National checks for applicants with less than 5-year state residency still cannot be done due to a conflicting federal law.

10. **Question:** Do all employees have to have a criminal history record check?

Answer: The criminal record check law went into effect January 1, 1997. Staff members hired after, not prior to, that date are required to have been checked. If the administrator is the owner of the facility and, therefore, the employing entity, a criminal record background check as required by this law is pointless since the information is strictly confidential to the hiring entity and intended to be used for hiring purposes only. All we as regulators can look for is evidence that the checks have been done such as receipts of payment for the checks.

The Editor's Note to the law states that it is applicable to applicants who apply for employment on or after the effective date of the law.

11. **Question:** Does Health Care Personnel Registry reporting apply only to employees or payroll staff of the facility?

**North Carolina Department of Health and Human Services
Rule Interpretations**

Forms/Records

Section 600

Answer: No. Under General Statute 131E-256, Health Care Personnel Registry, an adult care home is obligated to report to the Health Care Personnel Registry of the Division of Facility Services allegations which appear to be related to the neglect or abuse of a resident, misappropriation of property, diversion of drugs and fraud by health care personnel. Health care personnel in adult care homes is defined the same statute as an “adult care personal aide who is any person who either performs or directly supervises others who perform task functions in activities of daily living which are personal functions essential for the health and well being of residents...” It is important to note that the definition says “any” person. Therefore, the person does not have to be an employee or payroll staff of the facility for the facility to be subject to reporting an allegation. Even if the person is employed from a staffing agency by a family member of the resident and this person is performing tasks as stated in the law, the facility is responsible for reporting any allegation specified in the law against this individual. The facility is ultimately responsible for the safety and protection of residents under its care and, therefore, is responsible for reporting according to the requirements of the law regardless of the employment status of the individual authorized to provide or supervise personal care tasks.

12. **Question:** Is there a requirement for lab results to be maintained in the resident’s record or for lab results to be sent to the facility?

Answer: No. The facility is required to have documentation that care or services are provided as ordered. If a resident has orders for lab work, the facility is required to have documentation that the lab work was obtained and to ensure that the physician is aware of the lab results. Documentation by the facility that lab work is obtained as ordered may vary from documentation by the outside agency in the resident’s record to a copy of a lab form that indicates the lab work obtained. Documentation by the facility or the outside agency would need to be specific enough for it to be determined that labs ordered were obtained.

13. **Question:** What does “quarterly” mean regarding time frame requirements in rule?

Answer: Some of our adult care home rules state that certain things must be done on a quarterly basis such as medication reviews and licensed health professional support assessments/care plan reviews. Quarterly means at least every three months or occurring at three month intervals. It does not mean once every calendar quarter. The approximate time period is every 90-93 days but it was decided not to use this terminology in rule so that the emphasis would not be on counting specific number of days. If an LHPS assessment was done the middle of January, another one should be done by the middle of April. Quarterly refers to a three-month time period from the time the assessment or review was last done. Once again, it does not mean it has to be done one time at some point during each calendar quarter.

**North Carolina Department of Health and Human Services
Rule Interpretations**

Health Services

Section 700

1. **Question:** Can a Family Nurse Practitioner or a Physician Assistant record and sign orders without these orders being co-signed by a licensed physician?

Answer: Yes, the language in the rule which refers to physicians also applies to nurse practitioners and physician assistants when they are performing duties authorized by the supervising physician. State law pertaining to nurse practitioners (G.S. 90-18.2) states that “any prescription written by a nurse practitioner or order given by a nurse practitioner for medications, tests or treatments shall be deemed to have been authorized by the physician approved by the boards (the Board of Medical Examiners and Board of Nursing) as the supervisor of the nurse practitioner and such supervising physician shall be responsible for authorizing such prescription or order” (parenthetical statement added).

This applies to orders written on the health services record for adult care residents. It is not necessary for the supervising physician to co-sign orders. The law does require the physician to review the orders within a reasonable time, but this is the physician’s responsibility and not something monitored by the county DSS or Division of Facility Services.

This response also applies to a question raised as to whether a Family Nurse Practitioner could provide the medical examination required of an applicant administrator and supervisor-in-charge. If this is a function approved by the nurse practitioner’s supervising physician, then it is an acceptable practice. We do not want to impose a barrier to the proper performance of duties of qualified health professionals.

NOTE: A physician must sign the FL-2 and the resident care plan. Medicaid and Public Assistance require a physician’s signature for payment and reimbursement purposes.

2. **Question:** What responsibilities and options does an adult care home have when a resident’s doctor refuses to cooperate and sign verbal orders? Must the home be cited with violations? Can the home ask the resident to change doctors?

Answer: The rules do require the physician to sign orders, given by telephone, within 15 days from the date the order is given. This is to be done on the health services record used by the home.

The home is responsible for clarifying to the physician that countersigning of verbal orders is required by the licensure rules and that the home is held accountable when this is not done. While not all physicians will always fully cooperate, no exemptions or waivers of the requirement are possible.

A home is advised to first try to prevent this possible problem by informing physicians of their need to countersign. This should be done directly when the physician visits the home and could be done by attaching a note to the health services record when it accompanies the resident to the physician’s office. The note could say something as simple as:

**North Carolina Department of Health and Human Services
Rule Interpretations**

Health Services

Section 700

Please sign the orders you gave by telephone to (name of home)
_____ on (date) _____. The physician's
countersigning of verbal orders is required of the home. Thank you for your assistance.

If the physician still does not sign the orders, the administrator or administrator/supervisor-in-charge should make a brief note to this effect explaining what the home did to try to get the signature and keep this note in the resident's record. The next time the physician visits the home or the resident visits the physician's office, the home should again attempt to get the orders countersigned. A telephone call to the physician by the home may be necessary as a reminder and to confirm that the orders are still valid.

In deciding at what point to cite the home for a rule violation, the Adult Home Specialist should consider what efforts the home has made to comply. If there is no evidence of the home having attempted to get the physician's signature, the home should be cited for a violation.

Finally, failure to sign a health services record is not by itself sufficient reason to advocate that the resident get another physician. If the concern is that the physician is not giving adequate attention to the resident or cooperating well enough with the home so that it can adequately care for the resident, the administrator may encourage the resident to see another physician but cannot force the resident to do so. The rules allow the resident or his/her responsible party to choose a physician to attend to the resident.

3. **Question:** May an adult care home administrator refuse to permit "first responders," who are trained EMT personnel, to enter a home in response to a call by the home for an ambulance? The "first responder" would routinely arrive at the home prior to the arrival of the ambulance.

Answer: An early response to emergency calls by local emergency personnel may be an important part of the emergency medical services system to ensure appropriate health services to the residents of a rural county. Since the adult care home residents reside in the county, all appropriate health services should be available to them.

4. **Question:** Must a new FL-2 form or patient transfer form be completed for a resident who is kept overnight in the emergency room for observation?

Answer: If the resident remains in the emergency room or hospital overnight for observation and no treatment or change in current medical care is ordered, then a new FL-2 or other discharge/transfer orders would not be necessary. Documentation of the occurrence of an observation period should be included in the resident's report of health services.

5. **Question:** Must a resident be reassessed upon return from a hospital stay? Must a resident be reassessed if he/she is transferred from one adult care home to another if both homes are owned by the same administrator?

North Carolina Department of Health and Human Services
Rule Interpretations

Health Services

Section 700

Answer: For the purposes of the resident assessment, a resident who returns to the home from the hospital is not considered a new admission and would not have to be reassessed unless the resident's condition is considered to be a significant change in condition. However, if a resident is admitted to another licensed home, even if owned by the same administrator, the resident would have to have an assessment completed within 30 days of admission. If the location of the home changes and all the residents of the former home are moved to the new location, the residents would not have to be reassessed.

6. **Question:** Can a portable gate which is typically used to confine a child to a particular area be used at a bedroom door of a resident who wanders and who may fall?

Answer: While the rules do not specifically address a gate this is considered seclusion and thereby not allowed in the Adult Care Home. In addition, such a device would be considered a falls risk as the resident may attempt to climb over the gate thereby risking serious injury from falling.

7. **Question:** Are adult care homes required to weigh residents on a monthly basis?

Answer: A resident's weight should be measured and documented in the resident's record according to the following:

There should be at least an annually documented "baseline" weight from which to determine weight loss or gain. Weight is to be recorded on the FL-2 and will therefore provide the annual weight documentation. The administrator needs to assure that this information on the FL-2s or that a weight measurement and date is documented in the resident's record at least annually.

On observation of unplanned weight loss or gain, or of conditions that would cause weight loss or gain such as a noticeable change in appetite/food consumption that continues for several days, a resident's weight should be determined and recorded. There should be follow-up measurement and documentation within at least 30 days and at least monthly hereafter if an observable or measured decline or gain in weight continues.

8. **Question:** Does a resident with MRSA (Methicillin-Resistant Staphylococcal Colonization) need to be discharged or isolated?

Answer: Patients positive with MRSA do not require private rooms. The main infection control practice that should be routinely carried out in the long term care setting is hand washing between patient contacts. In addition, wound care using universal precautions with appropriate barrier precautions as outlined is necessary. Unless an outbreak has occurred, the routine use of isolation is not encouraged.

North Carolina Department of Health and Human Services
Rule Interpretations

Licensure Issues

Section 800

1. **Question:** Does the adult homes specialist have the right to look in all rooms of a licensed home, including the administrator's private living area?

Answer: Adult care homes are licensed by the State for the purpose of assuring the safety and welfare of the residents receiving care and services in those facilities. While the licensure rules governing adult care homes apply to areas of resident use, services and care, and there must be routine monitoring of these areas, the home is licensed for the protection of residents. Therefore, if there is reason to suspect a threat to resident health, safety and welfare in the administrator's or staff's private living or sleeping area, the monitoring agent should have access to that area.

2. **Question:** General Statute 131D-2(b)(1) states that a license shall not be renewed if outstanding state fines and penalties have not been paid. If an adult care home is operating with a provisional license and has an outstanding penalty fee, what is the appropriate action regarding licensure when the provisional license expires?

Answer: There is nothing in statute that would link the payment of fines to the provisional license status. Actions related to the expiration of a provisional license, i.e., extension of the provisional or return to full license, cannot be equated to renewal of the license. Therefore, if the expiration date for the provisional license is not the renewal date, the home is not required to pay the fine in full by that date.

3. **Question:** Is it allowable for adult day care centers to operate in adult care homes and if so, under what circumstances?

Answer: DFS will not issue two licenses for the same space. This type of co-location has been allowed when the adult care home and adult day care occupy separate space within the same building. There should be no sharing of staff, services, or regular programming. The adult day care certification rules for programs located in multi-use facilities require this separation within the building. This response takes into account the fact that there may be cases where such co-location is workable but also emphasizes that each of the two services has distinct objectives and must therefore be separated programmatically.

4. **Question:** What is the responsibility, if any, of the county department in the investigation of a complaint alleging illegal drug use by the live-in staff of an adult care home where there is no allegation of harm to the residents?

Answer: The county department does not have responsibility for investigating a complaint of a violation which does not involve the operation of the home and the care of its residents. Specifically, the county department should not be initiating an investigation of alleged illegal drug use by staff, live-in non-residents, or residents unless a complaint is received alleging such use is adversely affecting the residents. Even if such a complaint is received, the county department is advised not to initiate the investigation on its own. The local law enforcement agency should be informed of the complaint and asked to participate in a co-investigation.

North Carolina Department of Health and Human Services
Rule Interpretations

Licensure Issues

Section 800

The county department's staff are not equipped and are ill-advised to conduct independent, surprise drug searches.

5. **Question:** Are county departments of social services' adult care home records available as public information to interested persons (i.e. prospective residents, their families) and to what extent should the results of Protective Service evaluations be shared with residents and others not directly involved in the evaluation?

Answer: Both county and state records on each licensed home are a part of the official licensure and regulatory file and are therefore public records as defined by G.S. 132-1 and referenced in G.S. 131D-2 (b)(5). Access to this information can be handled in various ways, each of which may be acceptable. One way is for the records to be purged of all client identifying information and information identifying employees of the home, complainants or other persons providing information concerning a home. A second way is for the custodian of the records to maintain two separate files, the one with all client identifying information deleted being the record available to the public. A third approach would be to use a fact sheet or summary report on the home that could be prepared, using objective and current data contained in the record, and presented to the person requesting the information. A signed release of information would only be required when confidential or privileged information is being disclosed.

The county department, being custodian of the records, may develop in consultation with the county attorney, an agency policy regarding the procedure for access to these records. This policy could indicate a reasonable time frame to respond to a request for information that would give the county department time to prepare a fact sheet or purge the record of confidential/privileged information.

Regarding Protective Service evaluations, there would be no need to share the results with residents not directly involved in either the complaint or the evaluation. The administrator is responsible for informing the residents and their responsible persons of the reasons for a negative action imposed on the home by the Division of Facility Services (i.e., provisional license or revocation). In the event of this, it would be appropriate for the county department to follow up and determine if the residents had in fact been informed.

6. **Question:** May an adult care home be responsible for providing meals and medication administration to residents of apartments adjacent to the home who come to the home for these services?

Answer: Adult care homes are licensed to provide care and services to persons who are admitted as residents according to established admission rules and procedures. Staffing and services are based on resident census or capacity and meeting the needs of residents only. General Statute 131D-2 defines adult care homes and their licensure in terms of services to and for residents, including medication management. The home is licensed in order to provide room, board and specific services to residents of the home. Unlicensed or non-health professional staff in adult care homes are allowed to administer medications to residents only because of an exemption in the nurse practice act allowing them to do so for that clientele in

North Carolina Department of Health and Human Services
Rule Interpretations

Licensure Issues

Section 800

that specific setting. A home is going beyond its licensure bounds if it is providing services to non-residents. Home care/home health agencies are licensed to provide services, including medication administration, a person needs in their own place of residence.

7. **Question:** Since there is no adult day care licensure requirement for serving three or fewer clients, can an adult care home provide care and services for up to three persons on a day care basis?

Answer: An adult care home should not be serving persons under its license other than those admitted as adult care home residents with an appropriate FL-2, including those admitted for respite care according to licensure rule. Adult care homes are licensed by the State to provide 24-hour supervision, care and services according to statutes and rules to persons determined by a physician to need this level of care. Staffing, floor space, personal care, etc. as required in licensure rules are intended for residents admitted appropriately as adult care residents to the facility. Admitting and serving persons on a day-care basis who are not officially residents of the facility is an inappropriate use of required staffing and floor space designed to protect the health, safety and welfare of the residents. Since the facility is licensed to admit and provide for qualified residents, using staff, space and other facility resources to meet the needs of persons the facility is not licensed to serve infringes upon or compromises the use of required resources for whom they were intended.

**North Carolina Department of Health and Human Services
Rule Interpretations**

Medication Management

Section 900

Due to cross-reference in 13F .1001, all references to rules in this section are for 13G.

1. **Question:** Is it permissible for a family member to be responsible for and give medication to a resident? Would this be permissible if a physician ordered that the family member be responsible for medication administration?

Answer: Medication administration in an adult care home is the responsibility of the administrator and designated staff unless there is a physician's order for self-administration of medications (Rule 10A NCAC 13G .1005). If there is a self-administration order, family members could administer medications if the resident so desired, but to do so routinely would indicate the need to contact the physician for reevaluation of the self-administration order. Licensure rules only allow for self-administration or the administration of medications by designated staff. An order for a family member to be responsible for medication administration is inappropriate in an adult care home and, if followed, puts the home in the position of being out of compliance with licensure rules. If staff are not to administer medications and the resident is not self-administering, then the resident could be discharged because the home is unable to meet the needs of the resident for which it is licensed to meet.

2. **Question:** When a resident is released from a hospital without actual prescriptions from the doctor, can the FL-2 be used by the home to call the medications in to the pharmacist?

Answer: The pharmacist is responsible for determining if the order is appropriate for dispensing and is obligated to do so only with a complete order or prescription.

A prescription is written direction from a prescribing practitioner to a dispensing practitioner for preparing and dispensing a medication. A prescription or information required on a prescription is necessary in order for the pharmacist to dispense the medication.

An order is an entry in the resident's record for the administration of a medication. The home needs an order to administer a medication. A prescription may be used for an order, but it is not necessary for the home to have a prescription in order to administer a medication.

A prescription has the quantity to be dispensed and refill information and an order does not necessarily have this information. Information regarding refills is needed for the dispensing of a medication, but not for the administration of the medication.

3. **Question:** Regulation 10A NCAC 13F .0703 / 13G .0702 requires the completion of a FL-2 at the time of admission/re-admission and annually thereafter. If medications are inadvertently left off the FL-2 at the time of renewal, does the new FL-2 supersede the need for discontinue orders from the physician?

Answer: The FL-2 completed at the time of renewal does not supersede the need for discontinue orders from the physician. If a medication that a resident has been receiving is not listed on the FL-2, the physician should be contacted for clarification. Discontinuing a medication requires a discontinue order from a physician and should not be left to the discretion of the home based on its absence on the FL-2. Of course, if an order or

**North Carolina Department of Health and Human Services
Rule Interpretations**

Medication Management

Section 900

prescription specifies a particular duration of time for the medication to be taken, a D/C order is not necessary.

Note: In cases of hospitalization, the latest set of orders sent with the resident should be followed. Discontinue orders for medications not reordered following hospitalizations would not necessarily be required. The home should seek clarification on any orders that are unclear or when there are any questions regarding the administration of medications or the resident's care.

4. **Question:** Can the medication review for an adult care home be performed by a nurse, physician, or pharmacist who owns, manages, or is on the staff of the home?

Answer: One of the purposes of the quarterly medication review, according to Rule 10A NCAC 13G .1009 is to determine compliance with the orders of the resident's physician regarding the management of medications. Determination of compliance implies a process assuring impartiality and objectivity. Such a process cannot be guaranteed when a home's employee is responsible for determining the home's compliance. Therefore, a medication review should not be performed by a nurse, physician, or pharmacist who owns, manages, or is on the staff of the home for which the medication review is being conducted.

5. **Question:** What are the limitations for borrowing medications?

Answer: The only situation in which the borrowing of medications would be acceptable is in an extreme emergency situation in which death or serious physical harm is likely to occur unless the medication is quickly administered. If medications are borrowed, there must be accurate documentation and prompt replacement. [Rule 10A NCAC 13G .1004(o)]. The situation causing the need to borrow medication should be carefully evaluated and precautions taken to prevent the crisis from happening again.

Medications should never be borrowed for convenience purposes. The home should have a reliable medication procurement system in place, and rules require there to be arrangements for emergency pharmaceutical services so that there should not be a need to borrow medications. However, if a resident's prescribed medication is not available to treat a life threatening condition but the medication is available within the home, the circumstances would clearly indicate the need to procure and administer the medication as quickly as possible, even if that means borrowing the medication.

6. **Question:** How far in advance do requirements for medications prepared in advance apply (e.g. if 1st shift prepares 8:00 a.m. and 12:00 noon medication administration trays at 7:00 a.m., do 8:00 a.m. oral solid medications need to be kept enclosed in a sealed or capped container)?

Answer: The rules require the home to follow certain procedures if medications are prepared for subsequent administration. The intent of these required procedures is to keep the medications identified up to the point of administration and to protect them from

**North Carolina Department of Health and Human Services
Rule Interpretations**

Medication Management

Section 900

contamination and spillage. Under the rules, medications may be prepared for administration as much as 24 hours before the prescribed time for administration.

There are certain requirements which apply to the preparing of medications for administration regardless of the length of time between the preparation and subsequent administration. First, the medications must be kept in such a way that they can be identified up to the point of administration, that is, it must be clear which medications are to be given to which residents. Second, the prepared medications must be kept in such a way that they are protected from contamination, spillage, and pilferage.

If the medications are to be administered as soon as they are prepared for administration, i.e. prepared and administered to a resident before preparing for another resident, they do not have to be kept enclosed in a sealed or capped container. Therefore, if the medications are prepared at 7:00 a.m. for administration at 8:00 a.m., these medications would have to be kept in an enclosed container for protection from contamination or spillage and labeled according to Rule 10A NCAC 13G .1004(f).

7. **Question:** Can “no-refill” labeling on medication containers be considered a discontinuation of the medication?

Answer: Facilities should not consider “no-refill” labeling on medication containers as a discontinuation of the medication. Discontinuation depends on the medication and the condition being treated. It is very risky to assume “no-refill” means the same thing. The home needs to seek and document clarification from the physician or pharmacist on the intent of the “no-refill” so that staff do not mistakenly assume this to be a discontinuation order with potentially adverse results. A stop or discontinue order would include orders that the physician has specified the number of doses or specific time for administration such as 10 days.

8. **Question:** Do rules prohibit adult care homes from having an emergency locked “box” that contains frequently prescribed medications?

Answer: An adult care home may not keep a supply of prescription medications to be used for any resident as needed (per doctor’s order) whether it be in an emergency locked box or any other location. Please refer to 10A NCAC 13G .1006(h). Over-the-counter medications or medications obtainable without a prescription may be stocked but may not be administered without appropriate authorization.

9. **Question:** Can a home refuse to do the required medication regimen reviews and provide back-up pharmacy services after hours if a resident does not use the pharmacy of the home’s choosing?

Answer: Arranging for medication regimen reviews and emergency pharmaceutical services is the responsibility of the facility as stated in Rule 10A NCAC 13G .1010. The responsibility of medication administration rests with the home’s staff unless self-administration has been ordered by a physician. If another pharmacy is chosen, it is

**North Carolina Department of Health and Human Services
Rule Interpretations**

Medication Management

Section 900

important that the resident or responsible person, administrator, and pharmacist work together to arrange for the timely delivery of medications. If a pharmacy is unable to provide timely delivery on a consistent basis, the home may require the use of another pharmacy since the home is responsible for assuring availability of medications.

10. **Question:** Must the medication storage box, when used, be attached to the refrigerator in addition to being locked?

Answer: The rule requires that “Medications shall not be stored in a refrigerator containing non-medications and non-medication related items, except when stored in a separate container. The container shall be locked when storing medications unless the refrigerator is locked or is located in a locked medication area.” [10A NCAC 13G .1006(g)].

The rules do not require that the separate locked box stored in the home’s refrigerator be attached to the refrigerator in some way. While it is a good idea since it should provide for safer and more secure storage, it is not a requirement. If the home has problems with security of the box, it may be necessary to have it secured to the refrigerator or kept in a separate refrigerator that can be secured.

11. **Question:** What procedures would be proper for issuing single dose medication for out of home consumption (such as 12:00 noon dose for workshop participants)?

Answer: This is a question for which there is still not ideal solution. A number of homes are having to deal with this and are doing so in a variety of ways, some workable and others that raise concerns.

Single doses of medication may be provided by the home to some other responsible party for one planned administration away from the home. The home has responsibility for giving necessary instructions for administration of the medication(s) to the responsible party. It is obviously preferable that the medication not be given directly to the resident for subsequent administration since the resident should not be presumed to self-administer away from the home if he/she cannot do this at other times of the day.

Some pharmacists are working with homes to “split” a prescription for administration at a regular day activity and for use in the home, and only charging for one prescription. For example, a medication to be administered three times per day may be “split” into two medication containers, one having enough medications for one administration each day at the outside activity program and the other having sufficient medications for administration in the home.

Each of the separate medication containers for the “split” prescription must have the complete labeling. The home assumes responsibility for making the medication container available to the responsible party (e.g. ADAP staff person) who will give the medication(s) to the resident at the appropriate time. The home should document the date the medication

**North Carolina Department of Health and Human Services
Rule Interpretations**

Medication Management

Section 900

container is provided to the responsible party and the name of the responsible party. Effective communication with this responsible party is critical to make sure that the medication supply remains adequate and so that any problems in the resident's taking of the medication(s) are known.

The home should have as part of its medication management procedures a description of whatever practice it follows in residents' temporary absence from the home including documentation regarding release of medications to residents. [Rule 10A NCAC 13G .1003(f)].

In the case of a resident absent from the home during the time of a planned medication administration, the designated staff of the home responsible for charting the medication administration should indicate this absence on the medication administration record. One way this can be done is by circling initials and documenting "temporary absence" in the appropriate time block on the medication administration record.

12. **Question:** As outlined by the adult care home rules, specific requirements are identified regarding information to be included on each container label of prescription medications. How is this particular rule enforced on prescription medications dispensed by a pharmacy of the Veteran's Administration, given that often the V.A. labels do not have all of the information required by the rule?

Answer: Pharmacies within the Veteran's Administration are regulated directly by the Federal Government and are not bound by any state or local regulation. Therefore, the facility can only request that the V.A. pharmacist provide additional information on the prescription medication label that is not required by the Federal regulations. If all of the information required by the rule is not provided by the V.A., the facility should make an effort to stay abreast about the missing information to aid in its direct management of medications. As an example, if the most recent date of issuance is omitted, the facility may want to include this date on the medication administration record. The label itself should not be altered in any way by the facility staff. Also, the facility could consult with the local pharmacist regarding general characteristics of the medication precautions to be aware of. The pharmacist may agree to issue an auxiliary label which he/she believes to be necessary (e.g., restrictions on preparing medications for administration in advance). Realizing this is an area not within the facility's control, the facility should not be held accountable for omissions of V.A. prescription medication labels, if there is not a negative outcome from labeling.

13. **Question:** How should the facility handle medication orders with no duration or route of administration, including PRN medication orders?

Answer: The purpose of this rule is to prevent overutilization of dangerous and toxic medications, and all orders and labels should be handled as stated in these rules. Refer to regulation 13G .1002(c) and .1003(a).

The facility may request this information from the prescriber. Adult care home rules are not enforceable in regards to the actions of prescribing practitioners, but this does not, however, absolve the facility from the responsibility of meeting the intent of the rule. Therefore, the facility is to have procedures in place to ensure that the prescriber on a routine basis such as every 90 days reviews the resident's medications. It is the facility's and the pharmacist's responsibility to ensure that a safe medication system is established and implemented.

Route of Administration: The route of administration for medication should be stated in the medication order. However, if the prescriber does not indicate the route of administration, the facility and pharmacist should collaborate to have a policy and procedure to ensure correct administration.

14. **Question:** May the DMA 3050R be used for medication orders?

Answer: The DMA 3050R should not be assumed to be documentation of or an "equivalent" record for physician orders for medications per rules 10A NCAC 13F .0902(e) / 13G .0902(e) and 10A NCAC 13G .1002(c). The DMA-3050R consists of an assessment and a care plan. Medications are listed on the assessment section of the form (#1). Physician authorization and certification apply to the care plan per 10A NCAC 13F .0802(e) / 13G .0802(e) and are not intended to serve as medication orders. However, the physician may choose to use the medication section of the assessment for orders by signing this section to indicate such purpose.

15. **Question:** What is the appropriate use of the Medication Administration Record (MAR) and recording of signatures equivalents by an outside health care resource?

Answer: A MAR is required for documentation of medication administration-by the home's staff [10A NCAC 13G .1004(j)]. The use of the home's MAR by an outside source of medication administration is recommended for clearer record keeping and review purposes. However, the MAR requirement can be met if the record used by the outside source meets the recording requirements of the rule and is maintained in the resident's record

Recording requirements include a signature equivalent, which must be on the record or attached to it and applies to any source of medication administration using initials. If the signature equivalent is not directly on the MAR, it must be attached to or maintained directly with it. If the MAR's are filed together, there should be signature equivalent list filed and maintained with these forms if they are initialed. If a MAR is included in each resident's file/record, a copy of the signature equivalent list must be attached or included.

16. **Question:** If physician's orders for a non-prescription medication differ from the orders on the medication label, does the pharmacist need to re-label the medication?

Answer: When a physician orders non-prescription medications for a resident, these orders which are recorded in the resident's health services and medication administration records are to be followed, and labeling by a pharmacist is not required. Non-prescription

**North Carolina Department of Health and Human Services
Rule Interpretations**

Medication Management

Section 900

medications must bear the manufacturer's label with expiration dates clearly visible. If the non-prescription medication has been labeled by a pharmacist, the home should have a procedure for identifying direction changes such as auxiliary stickers that indicate directions have been changed.

17. **Question:** Is it permissible for an adult care home to have standing orders from a physician for non-prescription medications such as Milk of Magnesia, Mylanta, Aspirin, etc., and for the home to have these items on hand as stock medications? Who is responsible for payment for these non-prescription medications?

Answer: With respect to the first question, it is permissible to have standing orders from a physician for non-prescription medications. Specific directions for the quantity of the medication to be administered, frequency of use, and route of administration must be clearly indicated in these orders by the physician for all non-prescription medications to be administered. Standing orders should be for a short period of time only, such as 24 hours or six doses. These are orders implemented based on symptoms without contact with the physician. If administration needs to continue, the physician should be contacted for further instruction. According to rule 10A NCAC 13G .1002(e), standing orders are to be for individual resident and signed by the resident's prescribing practitioner.

In response to the second question, it is permissible for a home to maintain non-prescription medications under certain conditions. [Rule 10A NCAC 13G .1006(h)]. First, residents should only be receiving non-prescription medications as ordered by a physician. Second, the non-prescription medication container must bear the manufacturer's label with expiration dates clearly visible. Third, the non-prescription medications with standing orders, like prescription medications, must be available in the home and stored properly. Finally, a record of all medications given to each resident must be kept indicating each dose given. Stock non-prescription medications should be labeled as house stock (home's name written on it) in order for staff to know who it belongs to. House stock should not be intermingled with residents' medication.

The issue of payment of non-prescription medications should be discussed with the resident or his/her responsible person prior to or upon admission to the home as a matter of procedure. The administrator or supervisor-in-charge and the resident or his/her responsible person must complete and sign the Resident Register which covers plans for payment of medical expenses incurred by the resident.

18. **Question:** Are PRN medications as ordered by a physician to be available at all times in the home?

Answer: Medications for which there are physician orders have to be available in the adult care home whether the orders are designated PRN or otherwise. If PRN medications are needed and not on hand, the resident can suffer negative consequences ranging from prolonged discomfort to a life-threatening situation while waiting for the medication to be procured from outside the home.

**North Carolina Department of Health and Human Services
Rule Interpretations**

Medication Management

Section 900

19. **Question:** If a brand name medication is ordered for a resident, must the generic name of the medication appear on the label also?

Answer: The rules state that “a statement of generic equivalency shall be indicated if a brand other than the brand prescribed is dispensed”. [Rule 10A NCAC 13G .1006(a)(6)]. When a brand name medication is prescribed, the brand name is to appear on the label. If a generic equivalent medication is dispensed instead of the prescribed brand name medication, the generic name is also to appear on the label along with an equivalency statement regarding the brand name. When a generic equivalent medication is prescribed and subsequently dispensed, this is the only name, which must appear on the medication container label.

20. **Question:** May adult care homes accept and use samples of prescription medications?

Answer: Samples of prescription medications may be accepted and used if provided by a physician with a written order, or prescription. Prescription medication samples for short-term use (30 days or less) should be labeled with at least the resident’s name. Prescription medication samples intended for long-term use (more than 30 days) should contain labeling that includes: resident’s name, drug name, strength, directions, the prescribing practitioner, and date of distribution. Medication samples should be administered following the same policies and procedures applied to purchased medication. The facility should establish procedures for documenting the receipt of medication samples. Guidelines for proper handling of medication samples are available from the Adult Care Licensure Section.

21. **Question:** Can an administrator place an updated label on a medication container to indicate the most recent date of issuance if the pharmacist fails to do so?

Answer: Yes, as long as the prescription label is not altered and the information affixed is limited to information not specifically related to the dispensed medication, i.e., name of medication and strength. Refer to rule 10 A NCAC 13 G .1003 (c) for information .Labeling a prescription medication container is a part of dispensing and is restricted to registered pharmacists or other health care practitioners who are approved by the North Carolina Board of Pharmacy.

22. **Question:** Is it permissible for an adult care home to crush medications and mix them with food for administration to a resident who refuses to take it orally when there is no order from the physician for this method of administration?

Answer: Crushing medication and mixing it with food for ingestion by the resident creates several problems. A resident may not eat all of the food in which the medication has been mixed. Crushing and/or mixing medication with food could alter the medicinal properties of the medication. Rule 10A NCAC 13G .1002(c) states that “the medication orders shall be complete and include the following... route of administration...”. The physician must prescribe the method of administration of each medication for each resident and should be contacted if staff feel it is necessary. The home should have a policy and procedure for the crushing of medications. The home may have a standing order that states medications may

**North Carolina Department of Health and Human Services
Rule Interpretations**

Medication Management

Section 900

be crushed and mixed with food, unless contraindicated, but there should be a current “Do not crush” list for reference.

23. **Question:** What is an acceptable time frame for the administration of medications and treatments?

Answer: Administration of medications, including treatments, within 60 minutes prior to or after the scheduled or prescribed administration time should be considered timely. [Rule 10A NCAC 13G .1004(g)]. Of course, if a medication is ordered with specific parameters, i.e., in accordance with meals, then the 60 minute time period may not be applicable. For example, a medication ordered before meals and scheduled for 8 AM is administered at 8:30 AM, after the resident has eaten, would not be considered timely and would be a medication error. Finally, the medications being administered, the frequency of administration and the effect on the resident’s health and safety are always factors to be considered.

Other treatments and procedures that may not involve a medication being administered such as blood glucose monitoring should be done timely, i.e., within 30 to 60 minutes, of the scheduled or prescribed time. Again, the resident’s condition, treatment or procedure and any specific parameters would be factors in considering a reasonable time frame.

24. **Question:** Can an adult care home have a policy or include in the resident agreement or contract a statement prohibiting the self-administration of medications?

Answer: Self-administration of medication when ordered by a physician is allowed according to licensure rules 10A NCAC 13G .1005. Prohibiting self-administration when a the resident has been determined capable of doing so is a violation of the resident’s right to be treated with respect, dignity and recognition of individuality [G.S. 131D-21 (1)]. If there is no physician order for self-administration or it has been determined that the resident is not capable of self-administration, then the resident should not be permitted to self-administer. Any statements of blanket prohibition of self-administration in resident agreements or contracts should be revised accordingly.

25. **Question:** Are physician orders required for administration of herbal “medicines” to adult care home residents?

Answer: Yes, physician orders should be required for administration of herbal “medicines” to adult care home residents. The reasoning to support this is that, while herbal “medicines” are considered a dietary supplement, they are also defined as a “diluted drug” and can produce undesirable side effects and can interact with other medications or the action of other medications. In addition, the definition of a medication referenced in our rules is “any article, other than food or devices, intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease in man or in animals.” Since herbal “medicines” are a supplement, like vitamins, and not a food, this definition would apply and, therefore, call for physician orders. [Refer to Rule 10A NCAC 13G .1001(c)].

**North Carolina Department of Health and Human Services
Rule Interpretations**

Medication Management

Section 900

26. **Question:** Is a self-administration order from a doctor needed when a resident is on temporary leave from an adult care home for work, visit or other reasons and medications are given directly to the resident for self-administration?

Answer: There is no rule requiring self-administration orders or physician authorization for release of medications to residents on leave of absence from the facility who do not self-administer while in the facility. It is good practice and a strong recommendation, i.e., a "should" rather than a "must". This recommended practice is intended to protect the facility as well as the resident. As already established through interpretation, one dose of medication may be sent with the resident but more than that would require sending all the resident's medications or having the medications repackaged by a person authorized to dispense medications.

If a facility hands over containers of medications to a resident (as opposed to a family member or responsible party) leaving the facility temporarily and he/she is not self-administering in the home, it can be reasonably argued that there is a need for some documentation by a physician that the medications can be released to the resident. For many residents there is probably little risk in sending their medications with them directly when there is not a third party available. But there are also many residents in which such a practice would be very risky. If the medications were misused by the resident with harm resulting, the facility could be held at least partly responsible for the negative outcome. Besides being potentially subject to a civil lawsuit, regulatory action against the facility could possibly be taken depending on all the circumstances of the case.

Facilities are not required to have self-administration orders or physician authorization of release of medications for leave of absence situations. Most facilities probably do not have such a policy or practice in place but most residents probably leave, other than for very short-term absences, under the supervision of a responsible party. If, however, a facility did give medications to a schizophrenic resident on signing out on leave from a facility, and there was no documentation for self-administration or authorization for release of medications to the individual, regulatory action might be taken against the facility if the resident overdosed on the medications.

27. **Question:** Does a relief aide for several facilities who works during temporary absence of a medication aide have to have validation of the Medication Administration Clinical Skills Checklist completed for each facility?

Each facility is required to have documentation of competency validation for all staff responsible for the administration of medications. It is the responsibility of the registered nurse or registered pharmacist who is completing the clinical skills checklist to determine that an aide has demonstrated competency in performing the tasks or skills on the checklist.

**North Carolina Department of Health and Human Services
Rule Interpretations**

Medication Management

Section 900

The RN or RPh validating the tasks or skills of the aide would need to indicate on the checklist all the facilities this aide could be serving as a relief medication aide. The relief medication aide could only serve in that capacity in one facility at a time.

28. **Question:** Can an unqualified aide or staff person administer medications under the supervision of a qualified medication aide? (Unqualified aide refers to an aide that has not had competency validation of the skills or tasks on the Medication Administration Clinical Skills Checklist.)

No. An aide or staff person that has not been validated by a RN or RPh should not be administering medications in the facility prior to validation except when the aide/staff person is under the supervision of the RN or RPh. While training by a medication aide may be reasonable, the training can not be extended to the extent that the unqualified aide or staff person can administer medications under the supervision of the qualified medication aide.

If there are issues with unqualified staff administering medications, determination of whether the facility is in compliance or not would be by interview or staff, RN or RPh, administrator, etc. and review of documentation on the checklist or other facility documents. The RN or RPh do not have to initial or co-sign the MAR.

29. **Question:** If an aide or staff person does not pass the written medication exam within 90 days of the date the skills validation, may another checklist be completed and the 90-day period extended?

No. The medication skills checklist is to be completed before a staff person in an adult care home can administer medication. This is a one-time check-off of skills as long as the staff person works in the facility. The written exam must be completed within 90 days of the skills validation. Once the 90 days pass and the written exam has not been successfully completed, the staff person must cease from administering or be in violation of rule 10A NCAC 13F/G .0403. It is not within the intent of the rule to allow for an additional 90 days for passing the written exam by completion of the skills validation again at the end of the 90-day period or any time during that 90-day period.

30. **Question:** May unlicensed staff who meet the requirements for administering medication in an adult care home administer Epipens or other Auto Injectors?

Intramuscular auto injectors, such as Epipen, for use in emergency situations for allergic reactions may be administered by unlicensed staff who have been validated by a RN or pharmacist in their use (how and when to use). This validation should be able to be verified through documentation maintained in the facility. This is an exception to the prohibition of intramuscular injection by unlicensed staff per licensure rule because of the emergency nature for the use of the auto injector and the fact that the device automatically injects a specific dosage when administered. If a resident keeps an automated injector with him/her or

North Carolina Department of Health and Human Services
Rule Interpretations

Medication Management

Section 900

in his/her room with the intent of self-administration when needed, there would need to be a self-administration order on file.

31. **Question:** Rule 10A NCAC 13F/G .1004(g) requires that medications be administered within 1 hour before or after the prescribed or scheduled time of administration. What needs to happen if a resident is out of the facility and does not return within this time frame?

The intent of the rule is to ensure that medications are administered to residents in a timely manner.

If a resident is not in the facility at the time of administration and a medication has to be administered outside the two-hour time frame, there should be documentation according to the facility policy and procedure of when the medication was administered or if the medication was omitted. If a medication cannot be administered in a timely manner, there are several factors to be considered such as the medication prescribed, the frequency of administration, how late or early the medication is being administered, i.e., minutes or hours after the prescribed/scheduled time. Due to all the factors to be considered with administration, the facility should contact a nurse, pharmacist or physician for advice about a medication being administered outside the required time frame. The facility must not simply omit a medication because the medication is not administered within that time frame. If the resident is out of the facility on a routine or frequent basis when a medication is scheduled, the facility should consult with a pharmacist, nurse or physician to determine if another administration schedule or other alternative would be appropriate. It is important that the facility's medication policies and procedures address this issue with specific guidance for staff as noted above.

**North Carolina Department of Health and Human Services
Rule Interpretations**

Personal Care and Transportation

Section 1000

1. **Question:** Is a home obligated to provide a resident with transportation to a day activity program which provides only activities which are not necessary for the treatment of a specific illness?

Answer: The home is not obligated to provide this transportation. Regular participation in a day activity program outside the home is not required of adult care homes. If a resident desires to participate in a day activity program outside the home, the home's obligation is to cooperate with the resident, his/her family and community resources to help provide this opportunity. The way in which the transportation is arranged may vary greatly from home to home and for that matter, resident to resident. There are numerous ways by which this transportation is currently arranged. Some day activity programs themselves continue to provide the transportation. This is an optional service for an ADAP receiving funds from the Division of Mental Health, Developmental Disabilities and Substance Abuse Services. Other day activity programs encourage an arrangement where residents who earn wages in the program pay part or all of the cost of the transportation. This is seen as consistent with the normalization goal of the program. Sometimes, a combination of resources enable residents to participate. This may involve the home transporting some residents to some central location where the residents are then transported by volunteers or by the day activity program, or pay to ride public transportation when available. Some homes provide transportation for residents out of concern for the residents' well-being and to attract residents needing this type of day activity experience.

2. **Question:** What is the extent of the home's obligation to assist a resident needing transportation to a kidney dialysis center?

Answer: Rules require that the home arrange or provide the transportation to the nearest appropriate health facility providing the needed kidney dialysis services. The home may seek to utilize available community resources in arranging for the transportation, but the resident should not have to miss a scheduled appointment because of the lack of transportation. The home must provide the transportation if it is unable to arrange the transportation. The home may not use this inconvenience as grounds for the discharge of the resident. If the home admits persons who need this routine health care outside the home, the home must be willing to provide the transportation if it cannot be otherwise arranged for the resident.

3. **Question:** With respect to the home's obligation to provide or arrange for the resident's transportation, is there a maximum distance that limits the obligation for transportation to health facilities in the home's local community and what constitutes "appropriate health facilities?"

Answer: Rule 13F .0906 and 13G .0906 intentionally does not limit the transportation requirement to the home's "community." The obligation is potentially broader than that. The home must provide or arrange the resident's transportation to another community if that is the location of the "nearest appropriate health facility." The decision regarding what constitutes the "nearest appropriate health facility" is one that the resident's physician must make. If the physician determines that the residents can only be examined or treated by a

**North Carolina Department of Health and Human Services
Rule Interpretations**

Personal Care and Transportation

Section 1000

medical specialist outside the home's community, the home must provide or arrange for the necessary transportation. The rule does not set a maximum distance nor limit the requirement to certain types of health services or providers.

4. **Question:** Can an adult care home adopt a policy regarding the distance to which the home is willing to transport residents to their physician?

Answer: Rules 13F .0906 and 13G .0906 speak to the responsibility of the administrator to provide or arrange for the transportation of residents to necessary resources, including transportation to the nearest appropriate health facilities. An adult care home resident has the right to choose his/her own personal physician according to G.S. 131D-21. The home cannot require a resident to use the "house" physician and deny transportation to the resident's physician of choice. A home can be reimbursed for medically necessary transportation through Medicaid or charge accordingly through its monthly rates for private residents. It is a violation of the resident's rights when a resident, who has been transported to his/her physician, by the home, is then required to use the home's physician of choice. It is possible, however, for the home to establish, prior to admission, whether the transportation to the physician of choice is reasonable, so that it is clear to the resident and family seeking admission that transportation to the resident's physician cannot be provided directly by the home because of distance.

The transportation issue involves balancing several factors including resident choice, nearness, and appropriateness. Therefore, while the resident has the right of choice, the home's responsibility for transportation takes into account proximity and appropriateness. Also, the rule does not require the home to directly provide the transportation but to assure its provision which could be through family or other means. If other means are not available, however, the home must provide the transportation to appointments to receive necessary health care. If it can be shown that the resident can only receive the appropriate medical care from a physician 20 miles away in the next county, then the home must assure that the resident is transported to this nearest, most appropriate medical resource. Otherwise, the family can transport the resident or the resident can choose a more local/community resource.

It should also be noted that if the resident contract or agreement specified that the home would transport the resident to a particular health/medical resource, any change in the contract or resident agreement requires notification of the resident or responsible party as much in advance as possible and an amended copy for review and signature.

5. **Question:** Who is responsible or liable for a resident when the home is providing transportation to activities or other services rendered outside the home?

Answer: The home has responsibility for a resident when it is providing transportation. As a private business, the home should have its own liability insurance coverage to protect against bodily injury in case of an accident.

6. **Question:** Are adult care homes required to provide transportation to residents attending a mental health day treatment program?

**North Carolina Department of Health and Human Services
Rule Interpretations**

Personal Care and Transportation

Section 1000

Answer: The rules state that “the administrator must provide or arrange for the residents’ transportation to necessary resources and activities, including transportation to the nearest appropriate health facilities, social services agencies, shopping and recreational facilities, and religious activities of the resident’s choice.” If the day treatment program is part of a treatment plan ordered by a physician who believes that the program is necessary for treatment of the illness, the home is required to provide or arrange for transportation for the resident to the program. The day treatment program should be distinguished from a program which provides only activities which are not necessary for treatment of a specific illness, as the administrator would not be required to provide transportation for those services.

7. **Question:** With regard to transportation, the rule states that “the resident is not to be charged any additional fee for this service.” Does this rule apply to Special-Assistance and private-pay residents alike?

Answer: “Additional,” in the context of a resident on public assistance, means in addition to the established monthly rate for board and care. Residents on Special Assistance are charged an established monthly rate for adult care. Any fees for transportation in addition to this rate are not allowed according to the rule. The intent of the rule is that transportation costs be included in the established rate for adult care so that residents will not be faced with many additional charges. It serves as protection against exploitation of the resident. This also holds true for private pay residents who are charged a monthly board and care fee as specified in the resident contract.

For the private pay resident, the resident contract is key to determining whether or not the charge for transportation is an additional fee. The contract must specify rates for resident services and accommodations. A contract specifying a flat monthly rate that includes services indicates that transportation, by virtue of being an adult care service stipulated in rule, is covered in the monthly fee; therefore, any other charge for transportation must be considered an additional fee prohibited by rule. However, if service costs are itemized charges specified along with charges for other services, the specific charges for transportation cannot be considered an additional fee. “Additional fee” in this context means any charges in addition to those specified for transportation in the statement of services and rates in the resident’s contract.

8. **Question:** Does a workshop suggested by a mental health case manager meet the criteria of “necessary resources and activities” for the provision of transportation?

Answer: A “suggested” workshop does not qualify as a necessary resource or activity. The workshop must be part of a required treatment plan, i.e., stipulated in doctor’s order, to enforce the home’s assurance of provision of transportation according to Rule 13F .0906 and 13G .0906.

9. **Question:** In an adult care home, is the use of a sign out register necessary for daily activities such as going to ADAP?

**North Carolina Department of Health and Human Services
Rule Interpretations**

Personal Care and Transportation

Section 1000

Answer: No, the use of the sign out register is not required for a resident regularly attending a community day activity. The intent of the sign out register is to provide the home with necessary information about the resident's whereabouts. Having the home re-enter the same information each day on a resident's routine participation in a community day activity would place an unnecessary burden on the home.

It is enough for the home to have the necessary information on hand about the resident's routine schedule of participation in ADAP or some other day activity program. This information should include the resident's routine departure time, expected time of return, the days on which the resident attends the program, and the name and telephone number of the responsible person at the program.

10. **Question:** What is the responsibility of a facility in leaving residents, who have a tendency to stray and wander, unattended in public areas?

Answer: The facility has the responsibility for the general welfare, safety and care of all residents of the home. Part of that responsibility is using good, sound judgment regarding the care and safety of the residents both at the home and on outings. Requests for guidance from health care professionals who are familiar with a resident about the strengths and limitations of the resident would be appropriate. These professionals are in the best position to evaluate the individual needs of their client and can make recommendations about the type and amount of supervision required for this resident.

11. **Question:** What is considered an appropriate time to get residents up, bathed, and dressed for the day? Is getting residents up and bathed at 4:30 a.m. when breakfast is not served until approximately 7:30 a.m. considered too early?

Answer: The rules do not address the time staff will get residents out of bed in the morning to dress and bathe. However, the Adult Care Home Residents' Bill of Rights does address the care and services received by a resident. Bill of Rights #2 states that every resident has the right to receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. As the home does not serve breakfast until 7:30 a.m., it does not seem to meet the criteria of being appropriate to make residents get up at 4:30 a.m. to prepare them for breakfast when this is done to accommodate the home's staff and is not the resident's stated preference.

12. **Question:** May an adult care home have policy statements disclaiming any liability for resident accidents and injuries?

Answer: Disclaimer statements in no way affect the liability of an adult care home for a violation of statute and licensure rules. A licensed adult care home is responsible for the supervision and protection of residents whose ability for self-protection due to age or disability is compromised; therefore, statutory or regulatory liability cannot be waived by a

**North Carolina Department of Health and Human Services
Rule Interpretations**

Personal Care and Transportation

Section 1000

disclaimer statement but must be determined on a case-by-case basis through the regulatory enforcement process.

13. **Question:** What is the liability of the facility when a resident leaves of his/her own accord every day?

Answer: Adult care homes are not absolved of responsibility for residents who leave the facility on their own and not under the supervision of a responsible person. Residents' freedom to leave the facility on their own should be consistent with their abilities to make informed judgments regarding self-protection. These homes are responsible for residents' care and supervision and need to apply due diligence to assure their safety at all times. If it is believed that a resident's health or safety is threatened by leaving the facility on his/her own, these concerns should be discussed with the resident, responsible person and county department of social services and documented along with any response by a health professional to this effect. The resident's care plan should reflect these concerns, particularly in the areas of mental status, orientation, memory and behavior. If this resident insists on leaving, even if he/she signs out appropriately, it is the responsibility of the administrator to talk with the resident and responsible person about making other plans for the resident. Clearly, if the resident refuses to follow the sign-out policy as required by licensure rule.

14. **Question:** What is the liability of an adult care home for a resident who has left the home under the supervision of a responsible party?

Answer: If a resident is on a visit or outing from the home with a responsible party and has signed out or has been signed out of the home according to Rule 13F .0906(f)(3) or 13G .0906(f)(3) and any necessary medication provided as needed during the absence from the home, the home should not be liable for the health, safety, or welfare of that resident. When the resident is with a responsible person as indicated on the resident register, he/she cannot be considered under the direct care and supervision of the home. However, if the resident does not return to the home well-past the expected time of return as indicated on the resident register and there has been no notification from the resident or responsible party or ability to contact the responsible party, there may well be reason for concern about the whereabouts and safety of the resident, depending on the circumstances of the particular situation.

15. **Question:** Is it a requirement for an adult care home to carry liability insurance on the residents?

Answer: In North Carolina, insurance requirements are imposed by the licensing agency, as illustrated by automobile insurance requirements being set by the Division of Motor Vehicles and do not impose an insurance requirement for licensure. The Division of Facility Services is the licensing agency involved with adult care homes. The owner of a home, in keeping with good business practice, should investigate the insurance necessary to protect his clientele, his investment, and his operation. The financial resources of the administrator may

**North Carolina Department of Health and Human Services
Rule Interpretations**

Personal Care and Transportation

Section 1000

be strained in the event the administrator has not provided adequate or appropriate coverage and is sued by a resident or his responsible party. The maintenance of the home's plan of operation and delivery of services might then become a concern of the county department of social services.

16. **Question:** What is the responsibility of the facility for disoriented or confused residents who are transported for medical appointments?

Answer: The supervision of a confused or disoriented resident while waiting for the appointment to which the facility has transported them must be assured by the facility. If the facility does the transporting, the resident is under care of the facility. Family members may be requested, but not required to stay with the resident, or other arrangements may be made to assure the safety of the resident; but if no other resources are available, the responsibility lies with facility staff.

17. **Question:** Is an adult care home required to assure transportation to all medical appointments?

Answer: Yes, according to Rule 13F .0906 and 13G .0906, transportation to necessary medical resources must be assured. Certain situations may arise that can preclude scheduled plans to transport the resident, in which case the home should make every effort to arrange alternative transportation, i.e., family or other staff that may be available. If this cannot be done, the resident's physician or dentist should be contacted as soon as possible to determine what other plans should be made and for the home to be advised on to what extent a delay would affect the health and safety of the resident. A decision on rescheduling should also be based on whether the resident is suffering discomfort that could only be relieved by the scheduled procedure. While the condition of the resident may not be considered an emergency, a delay of almost two weeks from the originally scheduled appointment for a resident suffering pain and needing attention due to other medical problems seems excessive. The facility should develop a plan to handle such situations in the future, i.e., how transportation can be assured when the designated transportation person is not available even if due to unforeseen circumstances; document its follow-through on those plans; and, if missing the appointment still could not be avoided, seeking prompt advice and action on rescheduling. An appointment lasting longer than expected and causing a delay in staff returning to the home should not be considered an unusual circumstance but one that could likely happen and for which the facility should have plans to handle.

**North Carolina Department of Health and Human Services
Rule Interpretations**

Resident Rights

Section 1100

1. **Question:** Under what conditions can a resident volunteer for work in an adult care home? What, if any, are the guidelines for any monetary compensation?

Answer: Adult Care Home rules do not expressly prohibit employment or payment of residents for services. Labor laws including wage and hour laws would apply. However, work for therapeutic or medical/health reasons based on a physician's diagnosis would not be considered compensable time, i.e., subject to wage and hour laws regarding minimum wage. The US Department of Labor (919-790-2741) may be contacted for specific guidelines and questions regarding specific situations. Of course, monetary payment affects SA payment and can impact SA eligibility. An arrangement for providing a resident with an in-kind contribution for a service or duty is not regulated and is a consensual arrangement between the resident and administrator.

Whether for an in-kind or monetary payment, a resident's service must never take the place of required staff fulfilling their responsibilities as stipulated in rule. In other words, residents should never be performing tasks in place of but only in addition to staff so that staffing and staff fulfillment of responsibilities are in no way compromised. If a home is dependent on a resident to perform any service or function required in rule, it is out of compliance regarding staffing and in violation of resident rights.

2. **Question:** Are residents prohibited from drinking alcohol in adult care homes?

Answer: Adult Care Home rules do not prohibit residents' consumption of alcohol. However, the home's house rules must address alcohol consumption and must be provided to residents on admission. This means that alcohol consumption may be prohibited or permitted in the home with the following caveats. Alcohol abuse threatens the health and safety of the resident and others in the home and cannot be permitted. Also, residents with mental illness or disability or some form of dementia should not be permitted to consume alcohol except with documented approval from a mental health professional or a physician order. In addition, the dangers of interaction of alcohol with medications necessitates a doctor's order for consumption of alcohol. Therefore, in light of risks involved, if a home permits the consumption of alcohol, it should be treated like a medication and require an order or permission from an appropriate health care professional for its use by the resident.

3. **Question:** Can a home hold all tobacco products, restricting disbursements to one cigarette an hour? Could this stipulation be a part of the house rules?

Answer: This restriction should not be a blanket policy applying to all residents. Such a policy is too restrictive from a residents' rights perspective to be applied on any other than an individual basis in those cases where residents abuse the policy of smoking in designated areas only. The restriction should be documented in the resident's record indicating that the resident refused to abide by the smoking policy. As for including this restriction in the house rules, again, this is not an appropriate generic policy.

North Carolina Department of Health and Human Services
Rule Interpretations

Resident Rights

Section 1100

4. **Question:** Are adult care homes responsible for supervising residents when they leave the home for an off-site outing on their own?

Answer: General Statute 131D-2 states that adult care homes are to provide appropriate supervision based on the age or disability of the resident. Some residents may be able to go unsupervised into the community following the home's written visitation policy and compliance with rules on visiting (13F .0906(f) and 13G .0906(f). Others, based on their condition or past problems with unsupervised leaves, may need supervision on leaving the home. A blanket statement that the home has no obligation to supervise residents who leave the home does not absolve the home from its responsibility or liability. Any restrictions on visitation inside or outside the home must be stated in the house rules. A resident's freedom to leave the home needs to be consistent with his/her ability to make informed judgments regarding self-protection. If there is any question concerning this ability, consultation should be sought from an appropriate professional, documented, and plans made accordingly.

5. **Question:** The Adult Care Home Residents' Bill of Rights, General Statute 131D-21(5), provides for residents "except in emergencies, to be free from chemical and physical restraint unless authorized for a specified period of time by a physician according to clear and indicated medical need." What is considered to be an emergency in this instance?

Answer: Emergency situations for which the use of restraints may be considered are those which require intervention for the following reasons: 1) to prevent a resident from inflicting harm or injury to self or others, and 2) to prevent destruction of property or serious disruption to the immediate environment.

6. **Question:** Are double restraints allowed in adult care homes?

Answer: No. The use of more than one restraint on a resident at the same time is not an acceptable standard of practice in long term care or health care settings. Rules on restraint use refer to use of a restraint. Rules also require the use of **the least restrictive** restraint that would provide safety." The intent of the rule is that if a restraint is used on a resident, it is one restraint and specifically, the least restrictive restraint.

7. **Question:** When is a "lap buddy" considered to be a restraint?

Answer: A "lap buddy" is to be considered a restraint if the person on whom it is being used is unable to remove it easily without assistance. Ability to easily remove the device by the individual to whom it is applied, as it is so designed, is the determining factor for whether or not it is to be considered a restraint regardless of the ambulatory or weight-bearing status of the individual.

8. **Question:** Is it ever appropriate for a staff member to use a therapeutic hold on a resident in an adult care home?

Answer: There may be situations in which a therapeutic hold would be appropriate in an adult care setting, such as when a resident is uncontrollable or violent to the point of harming self or others. A therapeutic hold would be more appropriate than just any form of manual restraint to control a resident if the staff person was trained in the use of therapeutic hold. An employee does have the right to protect him/herself if physically attacked by a resident and the responsibility to bring under control as soon as possible a resident who is endangering others. If a resident is injured during such an incident, it must be determined whether unnecessary force was used by the staff person and what else could have been done in light of the circumstances surrounding the incident. In other words, the particular situation should be evaluated to determine if it was handled appropriately. It may be that a therapeutic hold is the best means of avoiding serious injury to resident and staff or other residents so that a statement forbidding the use of such restraint would not necessarily be in the best interest of resident and staff safety, nor could it be based on the restraint rule which refers to a physical restraint as any physical or mechanical device attached to or adjacent to the resident's body. Granted, there may be a potential for abuse, but its use may be justified in certain situations. However, if staff are trained and allowed to use a therapeutic hold, they should be trained as to when its use is appropriate.

9. **Question:** Can an adult care home have a policy or include in the resident agreement or contract a statement prohibiting the self-administration of medications?

Answer: Self-administration of medication when ordered by a physician is allowed according to licensure rules. Prohibiting self-administration when a doctor has determined the resident capable of doing so is a violation of the resident's right to be treated with respect, dignity and recognition of individuality (G.S. 131D-2, #1). If there is no physician order for self-administration or it has been determined that the resident is not capable of self-administration, then the resident should not be permitted to self-administer. Any statements of a blanket prohibition of self-administration in resident agreements or contracts should be revised accordingly.

10. **Question:** Can an adult care home require residents to use a pharmacy of the home's choosing?

Answer: An adult care home resident has the right to choose a pharmacy for the provision of his/her medications. This is guaranteed in Right #15 of the Declaration of Resident Rights (G.S. 131D-21) as freedom to participate by choice in medical resources. The home is to develop and implement policies and procedures regarding the medication administration system. The resident should have the right to choose his own pharmacy if the dispensed product is compatible with the system employed in the home and properly labeled. The home is ultimately responsible for ensuring that medications are available and administered correctly. The home should make it clear in its admissions policy if medications need to be dispensed in a certain way for administration in the home. This may limit to some extent the resident's choice of pharmacy but is not in violation of the resident's right of choice if a part of the admissions policy of the home. While the resident has the right of choice of

**North Carolina Department of Health and Human Services
Rule Interpretations**

Resident Rights

Section 1100

pharmacy, the home has the right to establish a safe and effective administration system and require upon admission that this policy be followed.

11. **Question:** While residents have the right to choose their physician and medical resources such as pharmacy or home health, if any one of these was not following the home's policies or providing services in such a way for the home to be in compliance with licensure rules, what recourse does the home have?

Answer: The home should make it clear what the home's policies are and what the licensure rules require of the home. If there was still no cooperation, the home would need to advise the resident and/or responsible person that services were not being provided according to policies and rules and that another physician or medical resource would need to be chosen. If the resident was unwilling to make the change, the home could make plans for the discharge of the resident. Of course, the home would need to document the problems and efforts at resolution.

12. **Question:** May a home require HIV testing of residents?

Answer: Title III of the Americans with Disabilities Act (ADA) prohibits private facilities which offer public accommodations, i.e. adult care homes, from discriminating against persons who are HIV infected. It does not specifically address whether or not a private home can require or request that the person be tested for a disability. What is clear is that the home cannot use the test results to discriminate such as in discharging or isolating the resident. It would also be a violation of ADA to invade the individual's privacy by trying to identify unnecessarily the existence of a disability. Current adult care home rules do not prohibit providers from testing for HIV. Providers are free to test for HIV whenever they and their attorneys deem such testing to be lawful. Testing can be required without concern for any legal challenge, however, only for those diseases which pose a direct threat to the health or safety of others such as TB. HIV disease is not such a disease since it is a bloodborne pathogen and homes are to follow OSHA guidelines for bloodborne pathogens. The home should be prepared to defend its requirement or request for HIV testing based on why it considers such information to be necessary.

The ADA is still a relatively new law. Its interpretation will be more clearly defined only after it is challenged in the courts. Based on consultation with state attorneys involved with the ADA, requiring HIV testing cannot be advised. Requesting HIV testing through written consent also appears to be on very shaky legal ground since there must be very clear non-discriminatory reasons for why that information is being sought. Also, identifying information regarding persons testing positive for HIV can only be released to the adult care home with the written consent of the person identified or his/her guardian. Consequently, having a resident tested does not mean the home will have access to that information as confidentiality laws govern disclosure for specific situations. If such information is disclosed appropriately, the administrator must have written consent of the resident or guardian for further disclosure except for those situations specified in G.S. 131D-2 (b)(4) and G.S. 131D-21 (6).

13. **Question:** Can a resident's possessions or bags being brought into an adult care home be searched?

Answer: A search may be requested and conducted only in direct response to documented evidence that the resident has brought something into the home that would threaten or jeopardize the health or safety of the residents or others in the home or that is in clear violation of the home's policies and rules. This in no way justifies a facility policy of inspecting all residents' bags brought into the home or a forced inspection of a resident's bags. Such a policy would be a clear violation of resident's rights. Also, the home should document the search and good cause for requesting the search such as a recent occurrence and its threat to the health and safety of those in the home. A resident may refuse a request for a search. The search should be a direct result of evidence and should not be a continuing occurrence. Continuing evidence of violation of house rules or of a threat to the health and safety of others should result in discharge of the resident according to Rules 13F .0702(b) and 13G .0705(b) rather than continual searches of the resident's belongings. Any search policy should be specific to an individual, for a very limited period of time to assure the safety of those in the home and, as stated earlier, in response to a documented situation or case justifying the need for the search.

14. **Question:** Can an adult care home require a resident to leave the home for holidays?

Answer: No. The adult care home is the resident's "home" and it is licensed to provide 24-hour supervision and care seven days a week throughout the year. There is nothing in rule or residents' rights that prohibits the facility from inquiring of the resident and responsible person of possible temporary leave arrangements for a holiday as long as it is clear that this is a request only with no coercion or indication that this arrangement is necessary or required by facility policy. Any indication in the home's policy and procedures or communication with the resident or responsible person that the resident must temporarily leave the home to accommodate holidays is a violation of the residents' rights.

**North Carolina Department of Health and Human Services
Rule Interpretations**

Staffing

Section 1200

1. **Question:** What is the definition of a relief-person-in-charge?

Answer: Relief management staff are intended for short-term, non-routine, occasional management coverage when the qualified administrator or SIC must be absent from the home, i.e., not able to perform that function at their regularly scheduled period of time. Someone hired and paid on an on-going basis to regularly serve in a management or supervisory function, whether it be more or less than 24 hours per week, should not be designated as relief personnel. If the relief person-in-charge is intended to routinely perform management/supervisory functions on a scheduled basis, the requirements for administrator or SIC are intended to be met for licensure compliance so that fully qualified persons provide this service.

2. **Question:** Can one of the required aides in an adult care home of 21-30 residents capacity serve simultaneously as an aide and the relief-person-in-charge when the administrator or supervisor-in-charge is absent temporarily?

Answer: No. The rules require both management and aide staff. The relief-person-in-charge is the temporary substitute management. The home also needs to have the necessary number of aides. This is not to say that a person who normally serves as an aide could not be designated relief-person-in-charge. It is saying that this cannot be a dual role. The home would still have to provide the minimum hours of aide duty using other personnel.

3. **Question:** Can employees serve in different staff positions during the course of a shift?

Answer: Employees serving in different staff positions is permissible as long as they meet all the qualifications of the roles they serve and the home has all the staff necessary to meet the requirements. Staff cannot serve dual roles simultaneously. For example, an aide may not be the designated housekeeper when staffed as an aide. Changing of roles by staff or management during shifts needs to be clearly reflected in staffing schedules except in emergency situations. This is especially important for aide staffing purposes since the rules specify hours of aide duty required. The schedule should indicate who is "on duty" on each shift and in what role that person is serving. For example, a person who is on duty as a cook cannot be serving as an SIC. If the cook serves as an SIC at another time, he/she must be qualified as an SIC or as relief personnel in the case of occasional, non-routine absences of management staff. Homes must have a discernible staffing pattern that assures the presence of management staff, the required number of aides for the number of residents or aide hours per resident, and sufficient personnel to perform housekeeping and food service duties.

4. **Question:** In multi-floor facilities, does a staff person always have to be on each floor? If so, could this requirement be waived if a staff person wore a pager/beeper connected to a call system?

**North Carolina Department of Health and Human Services
Rule Interpretations**

Staffing

Section 1200

Answer: No. A floor with residents should not be left unattended on any shift in a multi-story adult care home. A multi-level structure without staff on each floor leaves residents too isolated and not within easy access in case of an emergency. With regard to a call system, if the system does not activate or cannot be activated for some reason, a prompt response to an emergency is not likely when a staff person is not present on the floor. Resident supervision is an important dimension of adult care which should not be compromised by the use of a call system in place of staff on a floor who have the opportunity to hear and see what is happening and provide prompt attention.

5. **Question:** Is a home out of compliance with Rule 13F .0604(E)(2)(D) if the personal care staff are assigned housekeeping duties or are stationed out of view of the residents (particularly on third shift) if each resident has access to a call bell which is audible at the place where the aide is working or is stationed?

Answer: The rule has several qualifiers for aides performing housekeeping on third shift: not hindering care or immediate response to calls, not disrupting normal lifestyle and sleeping patterns, and not taking aides out of view of where residents are. All of these must be met if housekeeping is performed by aides. If the assigned housekeeping tasks include time-consuming duties which would require the aide to be in locations out of the purview of resident bedroom areas for more than several minutes, such assignments for the aides, at minimum staffing, do not meet the intent of the rule. Audible call signals do not take the place of visual surveillance since a disoriented resident may not use the call system. Further, a call system that requires a signal of sufficient volume for aides to hear while in those areas where third shift housekeeping is required may disrupt residents' sleep.

6. **Question:** Is it permissible for a supervisor-in-charge to perform laundry duties in adult care homes of 21 or more residents?

Answer: This may be done in short term situations in response to a critical need or emergency situations when housekeeping staff are not available. Laundry is a housekeeping function and not a management function and Rule 13F .0604 requires sufficient housekeeping staff in addition to management staff and aides. The primary responsibility of the supervisor-in-charge is the general management responsibility of assuring that all required duties are carried out in the home in the absence of the administrator. This involves a range of management tasks such as assuring proper medication management, supervising staff, handling residents' personal funds, maintaining proper record keeping in all areas, etc. In the light of these duties and requirements for housekeeping, management staff should not be performing laundry duty on a regular basis.

7. **Question:** In adult care homes, must the staff person who works night shift have a staff bedroom if that person is asleep and on call? Could a living room with a rollaway bed or sofa bed be utilized for staff sleeping purposes?

**North Carolina Department of Health and Human Services
Rule Interpretations**

Staffing

Section 1200

Answer: No. As indicated by the rules, “there must be bedrooms sufficient in number and size to meet the individual needs according to age and sex of the residents, the administrator or supervisor-in-charge, other live-in staff and any other person living in the home.” If it is the plan to allow the SIC to sleep at night, a staff bedroom must be provided. Required resident areas, in addition to the residents’ bedrooms, include areas which are available for common use by all residents (i.e., living room and dining room) and would not be appropriate for use as a staff sleeping area.

8. **Question:** In adult care homes with a capacity of 7-12 beds, is the night shift person allowed to sleep on a couch in the living room?

Answer: No. See above interpretation. Furthermore, if the staff person is sleeping in his/her respective bedroom, the adult care home rules require a call system connecting the bedroom of a staff member with each resident’s bedroom. The provision of a call system is clearly related to the safety of each resident in that he/she is able to receive immediate assistance in an emergency. Without such a system, residents who are in distress may have difficulty in calling for help, particularly if bedroom doors are closed and the staff person is asleep.

9. **Question:** Can an employee of an adult care home who provides transportation be counted as an aide in staffing requirements? Would a home be considered understaffed if one aide is not in the building due to short absences to take residents to physicians or community resources?

Answer: As stated in adult care rules, aide duties include direct personal assistance and supervision of residents. Transportation is an amenity type of service and not a direct personal assistance responsibility which involves hands-on personal care. This does not mean that an aide cannot occasionally be involved in transporting residents but staffing in the home must always meet minimum requirements for aides who must be available to supervise and attend to the personal needs of the residents. Therefore, an employee who has the primary responsibility for transportation cannot be counted as an aide in minimum staffing requirements. Additional hours of aide duty beyond the minimum may involve transportation.

The only allowable exception for less than minimum coverage is “during short, unforeseeable circumstances.” If the administrator plans to use an aide for routine transportation, an additional aide must be on duty during this time to maintain compliance with the minimum aide staffing requirement.

10. **Question:** In 12-bed homes, do the rules prohibit an administrator/supervisor-in-charge from assuming the duties of an activities coordinator, housekeeper, food service person and aide during a regular 8-hour shift?

**North Carolina Department of Health and Human Services
Rule Interpretations**

Staffing

Section 1200

Answer: No. In 12-bed homes, Rule 13F .0604 require that at least 12 hours be spent daily providing for the personal services, health services, medication management, meaningful activities and other direct services needed by the residents. In addition, the administrator is responsible for preparing a plan of operation identifying the staff involved and how the 12 hours of personal service are to be achieved. With regard to a 7-12 bed home, two staff are to be on each shift, at least one of who is an administrator or supervisor-in-charge in the home or immediately available. If the administrator or supervisor-in-charge is in the home caring for and supervising the residents, the other staff can be immediately available rather than in the home.

11. **Question:** In family care homes, can the administrator, SIC, or aide sleep while they are the only staff in the family care home during daytime hours?

Answer: There are no rules addressing the issue of appropriate sleeping hours for staff because of a well-founded assumption that on first and second shifts, when residents are most likely to be up and about, adequate supervision entails the staff person being awake. Sleeping at those times creates a substantial threat to the health and safety of the residents.

12. **Question:** Do adult care rules prohibit adult care residents from attending adult day care centers?

Answer: Adult care residents may attend adult day care center activities if they so desire and if they meet the necessary qualifications to attend. Supervision and care of the resident while at the day care program must be at least what is required in the adult care home and any special needs must be met regardless of setting. A physician's approval that this is an appropriate setting for the resident is important considering the amount of time he/she may be spending there. The home remains responsible for medication administration based on adult care home rules. Requirements for meals and snacks must also be met. The person continues to be an adult care home resident in the day care setting and the home must assure appropriate services in that regard.

13. **Question:** Are there any rules which would preclude the spouse of an employee of the Department of Health and Human Services (DHHS) from applying for the position of supervisor-in-charge of an adult care home?

Answer: The rules do not prohibit a spouse of a DHHS employee from being approved as a supervisor-in-charge. The DHHS employee should not, however, be assigned any official responsibility for the home where his/her spouse is working (e.g., inspection of home). As an additional note, a spouse of a DHHS employee would not be able to be approved as an administrator of a home which has residents receiving State-County Special Assistance (SA) funds. The N.C. General Statutes state that SA funds are not be paid for the care of adult care residents in a home which is owned or operated in whole or in part by a spouse of an official or employee of the Department of Health and Human Services or of any county department of social services.

**North Carolina Department of Health and Human Services
Rule Interpretations**

Staffing

Section 1200

14. **Question:** Is it permissible for an employee of an area mental health program to own/operate an adult care home and receive special assistance funding for its residents?

Answer: Yes. County mental health department employees are neither officials nor employees of the North Carolina Department of Health and Human Services. Likewise, these employees are neither officials nor employees of the county department of social services. Unless a county mental health department employee fits one of the other categories set out in G.S. 108A-47, an adult care home owned or operated by him may receive county special assistance reimbursement.

15. **Question:** In an adult care home, is it permissible for an aide from an outside agency to be appointed to regularly provide care to a specific resident? If so, how does this reflect on the rule that states that personal care services must be provided by staff of the adult care home? Will this effect how the adult home specialist monitors these services?

Answer: The home must have staff to perform necessary personal care duties, but this does not preclude someone appointed from another agency such as home health or mental health to provide care specific to the needs of a particular resident. Supervision of care and monitoring of the home should not be done any differently than it normally is. The administrator is responsible for seeing that residents receive appropriate care based on minimum requirements and the needs of the resident. If the resident does not receive adequate care according to the rules, the administrator would still be held accountable. The administrator's authority does not end with the provision of room and board and it encompasses the personal care of the residents no matter who may be directly providing it. The adult home specialist will monitor to assure required services are provided and the needs of the residents are being met and staffing complies with the rules.

16. **Question:** Rule 13G .0601 allows several options by which an administrator can manage the operation of his/her home. One option is for the administrator to reside within 500 feet of the family care home. Could a family care home administrator be working in an unrelated business within 500 feet of the licensed home?

Answer: The intent of the rule is to assure that an approved person is available and maintains, as a priority, the ability to respond to the needs of the residents. The administrator could be involved in an unrelated business in his/her place of residence as long as he/she is able to respond immediately to a situation in the adult care home.

17. **Question:** The description of aide duties in an adult care home of 21 or more residents states that "aides are not to be assigned food service duties; however, providing assistance to individual residents who need help with eating is an appropriate aide duty." What part may aides assume in the meal service and can they actually assist in serving residents?

**North Carolina Department of Health and Human Services
Rule Interpretations**

Staffing

Section 1200

Answer: The role of aides in a home is to provide the direct personal assistance and supervision needed by residents. During meal time, this may involve a variety of duties which directly benefit the residents. A primary duty is helping residents actually eat their meals (e.g., helping them cut their food, encouraging them, actually feeding those who need that amount of assistance). Other appropriate duties include assisting residents to and from the dining rooms when necessary so that residents receive their meals promptly with hot and cold foods at appropriate temperatures, bringing plates to tables, and “waiting” on the residents as needed (e.g., offering water, cleaning any spills).

In monitoring aides’ activity in relation to the food service, the focus should be on whether they are engaged in a good use of their time for the benefit not the detriment of the residents. While it is not beneficial to residents to have too strict interpretation of the statement “aides are not to be assigned food service duties,” this response is not meant to imply that aides can be used in the actual preparation of the meals. The home must have sufficient food service personnel for this.

18. **Question:** Is a substitute aide needed during a planned temporary absence of the aide on duty in an adult care home that employs minimum aide staff?

Answer: Aide staffing is based on the home’s licensed capacity or resident census. The only allowable exception is during short unforeseeable circumstances. During planned or extended absences of the aide on duty, a replacement aide must be present in the home.

19. **Question:** Is someone in a supervisory capacity required to be in a family care home when the residents all attend community programs during the day?

Answer: No. The day programs would need to be able to contact management staff immediately in case of an emergency or a resident requesting to leave and management would have to be available to make necessary arrangements.

20. **Question:** Is it correct that staff must live in a family care home rather than work there on a shift basis?

Answer: The staffing requirements outlined in Rule 13G .0601 can be fulfilled by having at least one staff person who lives in the home or one working on each shift. The rules do not require staff to live in a family care home. Hiring qualified staff on a shift basis to operate a family care home would meet the requirements in the rules even though the staff is not actually living in the home. At all times, however, at least one approved management person (administrator or SIC) who is directly responsible for assuring that all required duties are carried out must be in the home or within 500 feet.

21. **Question:** Are residents prohibited from using private sitters in adult care homes?

Answer: Adult care home rules do not address sitter services and, therefore, the use of a sitter is not prohibited if the resident or responsible person voluntarily chooses to employ one. If the sitter is to perform any personal care functions, it is the facility's responsibility to assure that the sitter is competent to perform those services, including medication administration. For example, if the sitter is to administer medications and is not a licensed health professional, the facility must assure the sitter is validated as competent to administer medications through the appropriate testing procedures as specified in rule. While the argument can be made that the sitter is not an employee of the facility, the resident is still a resident of the facility which is, therefore, liable for assuring appropriate care services are provided. The facility is still responsible for the health, safety, and welfare of the resident. If the sitter is to perform most or all personal care tasks for the resident, the question becomes one of whether the person needs to be in the adult care home since it is the facility's responsibility to provide personal care services along with supervision, room and board.

22. **Question:** How much time can a supervisor in a facility of 70+ residents devote to performance of personal care tasks?

Answer: Supervisors may be involved in personal care tasks, which includes medication administration, but the primary responsibility of this position is supervision of personal care aides. Up to a census or capacity of 70 residents, the supervisor can perform up to 4 hours of aide duty and have it count as aide duty hours on 1st and 2nd shifts. With a census or capacity of over 70 residents, none of the supervisor's personal care time on 1st and 2nd shifts can be counted as aide time and the rule does not address how much of the supervisor's time can be devoted to personal care. The supervisor should not be involved in personal care to the extent that it does not allow performance of the supervisory functions as needed. Time allotted to personal care by the supervisor should depend on whether aides are performing their tasks appropriately based on observation, complaints, etc. and whether they feel like they are supervised sufficiently based on interviews. Numerous problems or complaints that involve or reflect on the performance of aides is an indicator that more supervision is needed than is being provided. Some aides will require more supervision than others. The only way we can require a maximum number of personal care hours or minimum number of supervisory hours for supervisors across the board is for the rule to specify such. Otherwise, it has to be done on a case by case basis based on evidence that aides are not receiving the supervision they need. Even where supervisors can provide up to four hours of aide duty as official aide duty time, the rule does not limit additional personal care time by the supervisor other than not allowing it to be counted as aide duty.

23. **Question:** Does a home have to have someone on site at all times who meets the medication competency requirements?

Answer: A home has to have competent personnel to perform medication administration, which includes not only directly administering medications to a resident but also taking/transcribing physician orders. There is no requirement that the person who is qualified to administer medications has to be on site at all times, but the residents' needs

**North Carolina Department of Health and Human Services
Rule Interpretations**

Staffing

Section 1200

have to be met. If there was a delay in administering medications or handling medication orders because a qualified person was not available, a home would be considered to be non-compliant.

**North Carolina Department of Health and Human Services
Rule Interpretations**

Assessment/Care Plan

Section 1300

1. **Question:** Is the quarterly on-site review and evaluation of a resident's health status and care plan, as specified in Rule 13F .0903 (13G .0903), required if a home health nurse and not facility staff is performing one or more of the tasks listed in the rule?

Answer: Yes. The on-site review and evaluation of a resident's health status and care plan by a registered nurse is required because the resident needs one or more of the tasks performed and not because the home's staff is responsible for performing the tasks.

2. **Question:** When does the resident care plan have to be completed?

Answer: Rule 13F .0802 and 13G .0802 states that a care plan is to be developed in conjunction with the resident assessment and that it must be signed by a physician within 15 days of completion of the assessment. Since the assessment must be completed within 30 days of admission, the maximum time allowed for getting the care plan completed is 45 days from the time of admission. The care plan is not complete until a physician has signed and dated it. While physicians need to be informed that the authorized care plan is needed within a certain time frame for state licensure purposes and the appropriate care of the resident, they are not held accountable in the enforcement of this rule which states that the facility shall assure physician authorization. Adult care home licensure rules do not dictate the actions of physicians. However, if the time frame is not upheld due to the physician's delay in providing the appropriately signed statement, the home is not at fault for the physician's failure to respond. In this case, the home should document contacts with the physician in attempts at getting the necessary authorization. If the physician is not willing to cooperate in complying with the rule, the home needs to consult with the resident and/or responsible person on acquiring the services of another physician who is willing to work within the required time limits that you must work under to comply with the rule.

3. **Question:** Does a new assessment have to be done on a resident returning from the hospital?

Answer: For the purposes of the resident assessment, a resident who returns to the home from the hospital is not considered a new admission and would not have to be reassessed unless the resident's conditions considered to be a significant change as noted in Rule 13F .0801(c)(1) and 13G .0801 (c) (1). However, if a resident is admitted to another licensed home, even if owned by the same administrator, the resident would have to have an assessment completed as required in Rule 13F .0801 or 13G .0801. If the location of the home is changed and all the residents of the former home are moved to the new location, the residents would not have to be reassessed.

4. **Question:** Do care plans have to be completed for Respite Residents?

Answer: Yes. Rule 10 NCAC 13F .0907 and 13G .0907 states the facility shall complete an assessment, which allows for the development of a short-term care plan prior to or at admission with input from the resident or responsible person. The assessment is to address the resident's needs, including, identifying information, hearing, vision, cognitive ability, functional limitations, continence, special procedures and treatments ordered by the

**North Carolina Department of Health and Human Services
Rule Interpretations**

Assessment/Care Plan

Section 1300

physician, skin condition, behavior and mood, oral and nutritional status and medication regimen. The facility may develop and use its own assessment instrument or use the instrument approved by the Department for initial assessments. The care plan shall be dated and signed by the facility administrator or designated representative and the respite care resident or responsible person.

1. **Question:** Is it appropriate for a physician to do competency evaluations of adult care home staff for personal care tasks and licensed health professional support?

Answer: No. A physician's training and expertise are in the areas of diagnosis and treatment and not in the direct hands-on care skills or tasks specified in the adult care home rules on staff training and licensed health professional support. A registered nurse or OT or PT, as indicated in rule, are best qualified for teaching and validating competencies as required for staff training and licensed health professional support.

2. **Question:** What is the correct way to verify that someone is CPR trained?

Answer: If the card or certificate issued for CPR training does not indicate one of the organizations specified in Rule 13F or 13G .0507, there needs to be documentation on file that the trainer who provided the CPR training is certified by one of these organizations as a trainer. The rule states that training must be provided by one of these organizations or a trainer "with documented certification as a trainer." If there is no documentation, the organization could be asked for verification. But the facility is responsible for assuring training by a certified trainer and should have documentation if there is no indication of training by one of the organizations specified by rule.

3. **Question:** If an adult care home occasionally uses a relief-person-in-charge, does this person have to be qualified for medication administration as specified in rule?

Answer: Staff of adult care homes, including family care homes, who administer or supervise the administration of medication must be qualified per Rule 13F .1001 (13G .1000). If a relief-person-in-charge on duty in a family care home administers medication, PRN or otherwise, or takes a medication order by telephone, this person must be qualified to do so. If a medication, including a PRN, needs to be administered and the relief-person-in-charge is not qualified, the facility would have to assure that a qualified person is immediately available to administer the medication. The use of relief personnel does not exempt the home from the requirement that persons administering medications are to be qualified. If the relief person is not qualified for medication administration, the home would be expected to have a procedure in place to assure medications are administered as ordered and, in the case of PRN medications, as needed, when the relief person is on duty. If the relief person is on duty during a regularly scheduled medication pass, that person would be expected to be qualified unless there are arrangements for a qualified person to administer the medications. If the relief person is not on duty during that time that routine medications are scheduled, but there are PRN orders, the relief person should know the facility's procedure to follow to contact a qualified person to administer the PRN medications if needed.

4. **Question:** Must persons participating in the adult care home personal care training program have sufficient proficiency in the use of the English language to be able to successfully complete the course and competency evaluation?

Answer: Yes. Not having such proficiency would put residents in adult care homes at risk. Clear communication, verbal and otherwise, is critical to the care of residents in these facilities. Language barriers involving speaking and understanding English would obviously create an obstacle to this communication and threaten the health and safety of residents which adult care homes are licensed to protect.

5. **Question:** How many CEU's are required for a supervisor in an adult care home's Alzheimer's special care unit?

Answer: The supervisor would have to complete at least 12 CEU's annually by virtue of being a supervisor and being assigned to a special care unit. Six of those CEU's must be dementia specific according to Rule 13F .1309(4). Since the supervisor would be at least supervising medication administration if not directly administering medication in the unit, he/she would have to have six CEU's related to medication administration according to Rule 13F .0403(c). The six hours of dementia training and the six hours of medication administration training would satisfy the 12-hour CEU requirement for this position.

6. **Question:** What are training requirements for individuals certified as nurse aides in other states?

Answer: If a staff person was certified as a nurse aide in another state with at least the required 80 hours of nurse aide training, it is not necessary that he/she take the adult care home personal care aide training. The person **must** have a certificate indicating successful completion of the nurse aide training. Accepting this training to satisfy our training requirements is permissible because these training programs are fairly standardized nationwide due to federal guidelines. Other training programs are another matter, however. There is no assurance of comparability of personal care service training, by whatever name it is called (personal care aide, personal care assistant training) received in another state even if the total number of hours of training equal or exceed our requirements. In these situations, DFS has asked for some documentation of comparability in addition to hours, i.e. instructor qualifications and content areas covered in training.

7. **Question:** Is the quarterly on-site review and evaluation of a resident's health status and care plan, as specified in the licensed health professional support rule required if a home health nurse and not facility staff is performing one or more of the tasks listed in this rule?

Answer: Yes. The on-site review and evaluation of a resident's health status and care plan is required because the resident needs one or more of the tasks performed regardless of who is responsible for performing the tasks.

8. **Question:** What do the licensed health professional support assessments include?

Answer: Initial and quarterly assessments of residents requiring licensed health professional support as specified in the rule on licensed health professional support are to be "physical assessments of the residents are related to their diagnosis and current condition." A physical

**North Carolina Department of Health and Human Services
Rule Interpretations**

Licensed Health Professional Support/Training

Section 1400

assessment involves an on-site, direct “hands-on” assessment of the resident. This kind of assessment cannot be accomplished by just reviewing resident records or charts. The resident must actually be seen by the appropriate licensed health professional as specified in the rule.